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In The
Supreme Court of the United States
October Term, 1995

M. J. "MIKE" FOSTER, JR., In His Official Capacity as Governor of the State of Louisiana; RICHARD P. IEYOUB, In His Official Capacity as Attorney General of the State of Louisiana; and BOBBY P. JINDAL, In His Official Capacity as Secretary of the Louisiana Department of Health and Hospitals

Petitioners

v.

HOPE MEDICAL GROUP FOR WOMEN, On Behalf of Itself and the Medicaid-eligible Women of the State of Louisiana To Whom It Provides Health Care; IFEANYI CHARLES OKPALOBI, M.D., On Behalf of Himself and His Medicaid-eligible Patients Seeking Abortions; and ZORA H. (a Pseudonym), On Behalf of Herself

Respondents

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

1. Was it the intent of Congress in enacting the Federal Medicaid statutes within the statutory Chapter on Social Security to require those States which participate in the Medicaid program, by virtue of such participation, to include in their State Medicaid plans as a particular mandatory item or service of Medicaid coverage, to whatever extent Federal funds are appropriated and available for same, the performance of abortions for reasons which are other than to save the life of the mother but which are otherwise asserted by such abortion providers to be "medically necessary" and to obligate those States thereby to provide public funding therefor.

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No. 95

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On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITION FOR WRIT OF CERTIORARI

OPINIONS BELOW

Petitioners seek a writ of certiorari to review the judgment and opinion of the United States Court of Appeals for the Fifth Circuit filed on September 11, 1995, in *Hope Medical Group for Women, etc., et al. v. Edwards, etc., et al.*, reported at 63 F.3rd 418

(U.S. App. 5th Cir. 1995) rehearing denied October 17, 1995 (App. "A," pp. 1a-21a; App. "G," p. 39a).

The opinion of the United States District Court for the Eastern District of Louisiana in *Hope Medical Group for Women, etc., et al. v. Edwards, etc., et al.* is reported at 860 F.Supp. 1149 (USDC, E.D. La., July 28, 1994) (App. "B," pp. 22a-32a).

The denial of a stay of the United States District Court judgment, pending appeal, by this Honorable Court (*per* SCALIA, J.) *sub nom.Edwards v. Hope Medical Group for Women* (No. A-124) is reported at 115 S.Ct. 1, 129 L.Ed.2d 903 (August 17, 1994) (App. "E," pp. 36a-37a).

STATEMENT OF JURISDICTION

The judgment and opinion of the United States Court of Appeals for the Fifth Circuit sought to be reviewed herein was entered on September 11, 1995 (App. "A," pp. 1a-21a). After a timely filed petition for rehearing by Petitioners herein, a denial of rehearing was entered by the United States Court of Appeals for the Fifth Circuit on October 17, 1995 (App. "G," p. 39a). Under the Rules of this Honorable Court, this writ petition must be filed by mailing with the United States Postal Service on or before January 16, 1996.

The jurisdiction of this Honorable Court is invoked under 28 U.S.C. §1254(1) [1988].

CONSTITUTIONAL, STATUTORY, AND REGULATORY PROVISIONS

Louisiana State Law Provisions

La. R.S. 40:1299.35.1 (App. "H-1," p. 40a)

La. R.S. 40:1299.34.5 [prior to Act 1 of 4th Ex. Sess. of 1994] (App. "H-2," p. 40a)

La. R.S. 40:1299.34.5 [as amended and reenacted by Act 1 of 4th Ex. Sess. of 1994] (App. "H-3," p. 40a-43a)

Federal Statutory and Regulatory Provisions
42 U.S.C. §1396a (App. "I-1," pp. 44a- 114a)
42 U.S.C. §1396d (App. "I-2," pp. 114a- 138a)
Public Law 103-112, Section 509 (App. "I-3," p. 138a)
42 U.S.C. §1302 (App. "I-4," p. 138a)
Public Law 100-517, Section 9 (App. "I-5," p. 138a-139a)
42 C.F.R. §441.202 (App. "I-6," p. 139a)
42 C.F.R. §441.203 (App. "I-7," p. 139a)

STATEMENT OF THE CASE

Claiming jurisdiction under 28 U.S.C. §1331, 42 U.S.C. §1983, and Art. VI, cl. 2 [the Supremacy Clause], of the Constitution of the United States of America, plaintiffs-respondents Hope Medical Group For Women and Dr. Ifeanyi Okpalobi[1] filed a complaint in this action on April 6, 1994, naming as defendants Edwin Edwards, in his official capacity as Governor of the State of Louisiana, Richard Ieyoub, in his official capacity as Attorney General of the State of Louisiana, and Rose Forrest, in her official capacity as Secretary of the Louisiana Department of Health and Hospitals [the Petitioners herein].[2]

Plaintiffs-respondents sought declaratory relief based upon a claim that La. R.S. 40:1299.34.5 (App. "H-2," p. 41a), which prohibited the use of public funds or resources of the

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[1] In June, 1994, the original complaint was amended to add a new plaintiff, pseudonymously named Zora H. The amended complaint alleged that Zora H. was pregnant as a result of rape, that she was a Medicaid eligible person, and that she desired an abortion of this pregnancy. The amended complaint did not allege that Zora H. was being treated by either of the other plaintiffs. Zora H. sought the same relief as the original plaintiffs.

[2] In accordance with U.S. Supreme Court Rule 35(3), Louisiana's new Governor and new Secretary of the Louisiana Department of Health and Hospitals as successor public officers have been substituted as parties herein in the place of the former Governor and Secretary who were named parties in the courts below.

State for abortions other than to prevent the death of the mother, conflicted with Federal law—*viz.*, the Federal Medicaid law, Title XIX [42 U.S.C. §§1396 *et seq.*] of the Social Security Act [Chapter 7 of Title 42 of the U.S. Code, 42 U.S.C. §§1301 *et seq.*], as amended by Pub. L. No. 103-112, § 509, 197 Stat. 1082, 1113 (1993) [the then current "Hyde Amendment"] (App. "I-3", p. 138a)—and, since Louisiana participated in the Federal-State Medicaid Program, violated the Supremacy Clause, art. VI, cl. 2, of the United States Constitution. They also sought a permanent injunction to bar these state officials from enforcing Louisiana's statutory abortion funding restriction and eventually sought to require that the State of Louisiana immediately reimburse them for the cost of Zora H.'s abortion.

This "conflict" theory, based on the Hyde Amendment, a provision of the 1994 Federal appropriations act which prohibits expenditure of Medicaid matching funds for abortion except to save the life of the mother or to terminate pregnancies resulting from rape or incest, is premised upon plaintiffs-respondents' posited interpretation that, by this amendment, it was the intent of Congress to require mandatorily that all of the several States participating in the Medicaid program must begin, if they had not done so up to this time, to provide Medicaid funding for abortions in cases of rape and incest and was not the intent of Congress merely to make Federal funds available to those States which had optionally chosen on their own to provide such funding. The actual language of the then current version of the Hyde Amendment in question follows (App. "I-3", p. 138a):

> "None of the funds appropriated under this Act shall be expended for any abortions except when it is made known to the federal entity or official to which funds are appropriated under this Act that such procedure is necessary to save the life of the mother or that the pregnancy is the result of an act of rape or incest."

Pub. L. No. 103-112, § 509, 197 Stat. 1082, 1113 (1993).

Louisiana, a State whose law and legal values are historically rooted in Continental Europe's civilian codifications rather than the English common law, has a venerable tradition of recognizing and protecting the life of the unborn. The Louisiana Legislature has expressly declared that it is "the public policy of the state of Louisiana that it has a legitimate compelling interest in protecting, to the greatest extent possible, the life of the unborn from the time of conception until birth." 1991 La. Acts No. 26. In carrying out that public policy, Louisiana has chosen to prohibit public finding of abortions except where necessary to save the mother's life. La. R.S. 40:1299.34.5 (App. "H-1", p. 40a).

On July 28, 1994, the United States District Court for the Eastern District of Louisiana entered a judgment, enjoining the defendants from "enforcing LSA-R.S. 40:1299.34.5, insofar as it prohibits state funding for abortions to terminate pregnancies resulting from acts of rape or incest, as required by Title XIX, modified by the Hyde Amendment, while at the same time accepting federal funds pursuant to Title XIX". (App. "B," p. 32a). Thus, the court's judgment emphasized the contractual (consensual) nature of the State's participation in the Federal Medicaid program and the Federally-required conditions laid down for such participation rather than a preemption theory based on the Supremacy Clause. The court also denied Zora H.'s claim for reimbursement for the cost of her abortion, based upon its assumption that the state had "chosen not to accept federal funds under Title XIX, because they have refused to amend the law to provide funding in these very narrow circumstances . . . ." (App. "B," p. 30a). None of the plaintiffs-respondents, including Zora H., sought an appeal from this part of the judgment, and it is now final.

On August 1, 1994, defendants-petitioners filed a Notice of

Appeal seeking review of the July 28, 1994 Judgment. Also on August 1, 1994, defendants-petitioners applied to the district court for an order staying that court's judgment pending the appeal. The district court granted the motion for stay, but only to the extent that the Judgment was stayed until 5 o'clock p.m. on August 19, 1994 (App. "C," p. 33a-34a). Defendants-petitioners filed a second stay application seeking to have the stay extended for the pendency of appeal. The district court denied that request on August 9, 1994 (App. "D," p. 35a).

After defendants-petitioners applied to the U.S. Court of Appeals for the Fifth Circuit for a stay of the district court's July 28, 1994 judgment pending appeal, that court issued the following order:

> "IT IS ORDERED that the motion of appellants for stay pending appeal is DENIED; however, retaining jurisdiction we return to the District Court any management required of the injunction appealed from in this proceeding. This partial remand shall specifically include the discretionary power of the District Court to grant extensions to the stay previously granted by said court in the light of any circumstances that have or might develop during the appeal of this case."

On that same day, appellants applied to this Honorable Court for stay of the district court's July 28, 1994 judgment pending appeal. Justice Scalia denied that request on August 17, 1994, noting:

> "The only issue potentially worthy of certiorari is the premise underlying the District Court's decision that Title XIX requires States participating in the Medicaid program to fund abortions (at least 'medically necessary' ones) unless federal funding for those procedures is proscribed by the Hyde Amendment. The Courts of Appeals to address this question have uniformly supported

> that premise. [Citations omitted]. We have already denied certiorari in two of those cases, and it is in my view a certainty that four Justices will not be found to vote for certiorari on the Title XIX question unless and until a conflict in the Circuits appears."

Edwards, etc., et al. v. Hope Medical Group for Women, etc., et al., 115 S.Ct. 1, 2, 129 L.Ed.2d 903 (August 24, 1994) (App. "E," p. 37a).

Defendants-petitioners then reapplied to the district court for a limited stay, through August 25, 1994, so as to afford the Louisiana Legislature, then in special session, an opportunity to enact legislation that would address the Medicaid funding problem while at the same time preserve their right to seek a reversal on appeal. The district court thereupon extended its stay of judgment through August 25, 1994 (App. "F," p. 38a), and the Louisiana Legislature, during that period of the stay, enacted Act No. 1 of the 4th Exraordinary Session of 1994, which amended and reenacted La. R.S. 40:1299.34.5.

Essentially, the new version of La. R.S. 40:1299.34.5 (App. "H-3," p. 40a-43a), as amended and reenacted by Act No. 1 of the 4th Extraordinary Session of 1994, continues the ban on using public funds and resources of the State for abortions other than to prevent the death of the mother but specifically allows the funding of abortions in the case of rape or incest in order for the State to comply with the district court's order and to continue to participate in the Federal-State Medicaid program[3]; however, such allowed funding, in essence, remains in

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[3] Accordingly, this case does not present the uninviting risk presented in *Weil, etc, v. Hern, et al.*, U.S. Supreme Court Docket No. 95-701, that a State constitutional provision, properly construed as a restriction on the general powers of State government binding the Colorado State officials therein, would prevent them from agreeing to Colorado's continued participation in the Federal Medicaid program and would require Colorado's withdrawal

effect only as long as Federal law and a judgment or order of a court of competent jurisdiction requires it for Louisiana's participation in the Medicaid program and ceases thereafter. Moreover, it further mandates state officials to pursue vigorously and expeditiously judicial remedies seeking a reversal of any such judgment or order.[4]

On September 11, 1995, the U.S. Court of Appeals for the Fifth Circuit entered its judgment and opinion (App. "B," pp. 22a-32a). First, it held that the appeal of defendants-petitioners was not mooted by the amendment and reenactment, pending appeal and during the period of the extended stay granted by the district court, of La. R.S. 40:1299.34.5 (App. "H-3," p. 40a-43a). Second, it joined the Tenth Circuit [and op-

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therefrom to the detriment of Medicaid-eligible Colorado citizens who would lose their Medicaid benefits thereby.

[4] To understand Louisiana's dilemma is to understand that, within the context of its venerable tradition of protecting unborn human beings, the State of Louisiana, unlike most states, also maintains a charity hospital system that provides health care for its citizens who cannot afford the care otherwise. The charity hospital system and other programs for the needy rely heavily upon Medicaid funding. Most of the private rural hospitals, nursing homes, mental retardation facilities, and group homes, and all of the state's public acute hospitals, psychiatric hospitals, and group homes would close if Title XIX revenues were eliminated, as Medicaid revenues constitute the majority of those institutions' funding. In addition, the state's parish health clinics, mental health clinics and substance abuse clinics rely heavily upon Title XIX revenues. Their closure would result in the elimination of health care services to the mentally ill, mentally retarded and nursing home and other patients who depend upon Medicaid funding. Also, 27 non-state public/rural hospitals in Louisiana qualify for disproportionate share payments in return for treating a large percentage of the state's Medicaid and indigent population. These hospitals could not operate without Title XIX funding. The Louisiana Department of Health and Hospitals estimates that approximately 900,000 patients would be left without services if the state is denied Title XIX funding. Additionally, approximately 14,000 jobs in the health care industry would be lost.

posed the Eighth Circuit] in holding that the Hyde Amendment is merely a Congressional restriction on an appropriation, is not a substantive law amending the substance of Title XIX [42 U.S.C. §§1396 et seq.] of the Social Security Act [Chapter 7 of Title 42 of the U.S. Code, 42 U.S.C. §§1301 *et seq.*], and, therefore, does not impose any additional abortion funding requirements on States beyond those of Title XIX and the Social Security Act.[5] But third, it held that Louisiana's abortion funding restriction to cases in which the mother's life is endangered is in conflict with Title XIX, which the appellate court found to mandate certain manner of coverages.[6] A timely petition for rehearing was filed by Petitioners herein, and on October 17, 1995, the appellate court entered an order (App. G, p. 39a) denying the rehearing prayed for.

REASONS FOR GRANTING THE WRIT

This Honorable Court should grant the writ of certiorari sought herein not only because the judgment and opinion of the appellate court in this case created a conflict among the circuits on a compelling question of Federal law but also because another separate and distinct question of important Federal statutory law decided therein should be, but has not yet been, settled by this Honorable Court.

Conflict Among Circuits

Although the U.S. Court of Appeals for the Fifth Circuit below agreed with its Tenth Circuit counterpart that the Hyde

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[5] *Cf.* Statement of Congressman Henry Hyde, Congressional Record, June 28, 1994, at p. 5261.

[6] This aspect of the appellate court judgment and opinion is the only part adverse to Petitioners herein and gives rise to the "Question Presented for Review," supra. The resolution of the first two issues by the appellate court in Petitioners' favor leaves open the opportunity for a conditional cross-petition for a writ of certiorari by the Respondents in this matter.

Amendment "does not impose any independent obligations on states apart from the requirements of Title XIX," *Hope Medical Group for Women, etc., et al. v. Edwards, etc., et al.*, 63 F.3d 418, 424 (U.S. App. 5th Cir. 1995) (App. "A," p. 9a), this holding characterizing and construing the meaning of the Hyde Amendment is in direct conflict with the holding in *Little Rock Family Planning Services, P.A., et al. v. Dalton, etc., et al.* C/W *Orr, etc., et al. v. Nelson, etc., et al.*, 60 F.3d 497 (U.S. App. 8th Cir. 1995) characterizing and construing the meaning of the Hyde Amendment directly to the contrary.

Moreover, a petition for writ of certiorari to review this very same contrary holding by the Eighth Circuit in the *Orr* case is already currently pending before this Honorable Court in *Nelson, etc., et al. v. Orr, etc., et al.*, U.S. Supreme Court Docket No. 95-766.

According to the U.S. Court of Appeals for the Fifth Circuit in this case,

> "[T]he Hyde Amendment does not create substantive obligations. On its face, the Hyde Amendment merely restricts the use of federal funds for abortions.
>
> * * *
>
> Although the 1994 version of the Hyde Amendment permits the use of federal funds for abortions in rape and incest cases, the amendment contains no language obligating state Medicaid programs to fund abortions under these circumstances. Nor does the amendment purport to substantively amend Title XIX with respect to the authority of state Medicaid programs to tailor the scope of their medical coverage."

Hope Medical Group for Women, supra, 63 F.3d at 424 (App. "A," pp. 9a-10a).

However, the U.S. Court of Appeals for the Eighth Circuit

addressed this very same specific Federal question in the following manner:

> "The Nebraska defendants also argue this circuit's Hyde Amendment decisions, *Hodgson* [*v. Board of County Commissioners*, 614 F.2d 601 (8th Cir. 1980)] and *Reproductive Health Services v. Freeman*, 614 F.2d 585 (8th Cir.) (*Freeman*), *vacated on other grounds*, 449 U.S. 809, 101 S.Ct. 57, 66 L.Ed.2d 13 (1980), were incorrectly decided and urge the court to reconsider those precedents in light of *Harris v. McRae*, 448 U.S. 297, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980).
>
> "We must decline the defendants' invitation to overrule *Hodgson* and *Freeman*.
>
> * * *
>
> "In *Hodgson* this court rejected the defendants' arguments that the Hyde Amendment is merely an appropriations measure that did not substantively amend the Medicaid statute. In *Hodgson* we held that the Hyde Amendment in effect at that time which, like the 1994 Hyde Amendment banned federal funding for abortions except to save the life of the mother or in cases of rape or incest, 'altered Title XIX's requirements, with the result that, as a statutory matter, [the state] need only finance those abortions contemplated by the Hyde Amendment.' 614 F.2d at 605; *see also Freeman*, 614 F.2d at 591-92 (noting that *Hodgson* held that Hyde Amendment substantively amended the Medicaid statute).
>
> * * *
>
> "In sum, we hold the Arkansas state constitutional amendment and the Nebraska state regulation prohibiting the use of public funds for abortions except to save the life of the mother violate the federal Medicaid statute, *as amended by the 1994 Hyde Amendment*, and are therefore invalid under the supremacy clause."

Little Rock Family Planning Services, P.A. C/W Orr, supra, 60 F.3d at 502-503 (emphasis added).

A Second Important Federal Question Which Should Be Settled

This separate and distinct question of important Federal law decided by the U.S. Court of Appeals for Fifth Circuit below deals with the proper interpretation and construction of the underlying statutory obligations of the States under Title XIX of the Social Security Act to fund, as a particular mandatory item or service, the performance of abortions other than to save the life of the mother. Such a question subsumes related difficulties such as ascertaining the true legal meaning of what is "medically necessary" within the context of the entirety of the complex Social Security Act [Chapter 7 of Title 42, 42 U.S.C. §§1301 *et seq.*]. While the primary duty and object of all statutory interpretation and construction is to ascertain and give effect to the intent of the legislative body in enacting the statutes being considered, it is submitted that a plethora of lower court decisions have taken this important Federal question on a course which is tangential to true Congressional intent and destructive of it. This Honorable Court answered only part of this question in 1977 and left to another day the more difficult part of it, but the turmoil that has arisen with the 1994 version of the Hyde Amendment signifies that that day has now arrived and that this Honorable Court should now settle the rest of the question in order to establish stability and effectuate the true intent of Congress in the enactment of Title XIX.

Title XIX [42 U.S.C. §§ 1396 *et seq*] is but one facet and an integral part of the overall Social Security Act [Chapter 7 of Title 42, 42 U.S.C. §§1301 et seq.]. Indeed, the modern Medicaid form of Title XIX was but one facet and an integral part of the Social Security Amendments [Act] of 1965 (P.L. 89-97, June 30,

1965), by which it was enacted into existence. The overall purpose of Title XIX is broadly stated in 42 U.S.C. §1396 to be

> [the] enabling [of] each State, *as far as practicable under the conditions in such State*, to furnish
>
> (1) *medical assistance*
>
> on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services,
>
> and
>
> (2) rehabilitation and other services to help such families and individuals
>
> attain or retain capability for independence or self-care.

To enable each State to furnish such medical assistance and rehabilitation and other services within the scope, limitations, and parameters of the particular practicabilities existing within the conditions in such State, inasmuch as such practicabilities and conditions may vary from State to State, the Federal Medicaid payments are to be made "to States which have submitted, and had approved by the Secretary, State plans for medical assistance," 42 U.S.C. §1396. Obviously, these State plans are contemplated to be vehicles for implicitly identifying such practicabilities and conditions in the negotiation and line-drawing process which necessarily occurs in any State plan for implementing any Federal-State program using matching funds.[7] Accordingly, States have wide discre-

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[7] Louisiana's State Medicaid plan, as executed and approved by the U.S. Secretary of Health and Welfare and existing at the time this lawsuit was filed, drew the line at saving the life of the mother with respect to providing abortion services.

tion in determining the extent of services they are to provide.

42 U.S.C. §1396d(a) (App. "I-2," pp. 114a- 138a) sets forth a very broad definition of the term *medical assistance* by listing several very generalized categories into which single medical items or services are contemplated to fall. 42 U.S.C. §1396a (App. "I-1," pp. 44a- 114a) makes general provision for State Medicaid plans, and 42 U.S.C. §1396a(a)(10) (App. "I-1," pp. 46a-47a), in particular, appears to require that State plans include, as a minimum, the care and services intended by Congress to fall within categories (1) through (5), (17), and (21) contained in the 42 U.S.C. §1396d(a) definition of "medical assistance." This structure infers that among the broad and general legal definition of "medical assistance" there are, with respect to what is includable in any State plan, categories of mandatory services and categories of optional services.

The problem for classifying abortion coverage is that, within this statutory structure, the actual language describing these categories of services is replete with ambiguities, generalities, and vagueness, such that the categories, by any linguistic standard, are overlapping and any of several given medical items or services is clearly capable of falling into more than one category. While such ambiguity might have made little or no difference in the absence of classifying such categories as mandatory or optional, the apparent distinction between mandatory and optional categories for State plans can create utter confusion in attempting to discern whether it was the intent of Congress to require mandatory coverage, or to allow optional coverage, by States of any given medical item or service which is capable of falling into both mandatory and optional categories. Such is the case of abortion services.

Within the broad, general, and ambiguous terms used in the Medicaid statutes, abortion services could conceivably fall into any of the following categories (App. "I-2" pp. 116a-119a):

(1) inpatient hospital services (other than services in an institution for mental diseases);

(2) (A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)(1) of this section) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)(1) of this section) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (l)(2) of this section) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan;

(4) (A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; (B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r) of this section) for individuals who are eligible under the plan and are under the age of 21; and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies [*as when abortion is used as a "birth-control" device*];

(5) (A) physicians' services furnished by a physician (as defined in section 1395x(r)(1) of this title), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, and (B) medical and surgical services furnished by a dentist (described in section 1395x(r)(2) of this title) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental med-

icine and would be described in clause (A) if furnished by a physician (as defined in section 1395x(r)(1) of this title);

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(9) clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(12) prescribed drugs [*when the abortion is effected by an abortifacient*], dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive [*as when the abortion is performed to prevent birthing complications, the birth of a baby prenatally known to have developmental defects, or even the continuing residual emotional trauma from a rape or incest due to subsequent contact and association with reminders thereof (the asserted "medical necessity" in this case)*], and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;

(25) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary.

The first four categories above are mandatory categories; the remaining five are categories of optional items of medical care and services. Moreover, the performance of abortions in the manner conducted by Respondent Hope Medical Group for Women would appear to fall more clearly into the optional category of "(9) clinic services" than in any of the mandatory categories.[8] The stark language describing the mandatory category of "(5)(A) physicians' services" is overly broad, general, and vague, for if its plain language were taken literally, it would include medically-assisted suicide services, euthanasia services, and all sorts of wild medical experimentation—absurd consequences for statutory interpretation and obviously contrary to Congressional intent in 1965.

Thus, the question is not resolvable by resort to the plain statutory language, which is vague, general, overlapping, and ambiguous. Consideration must be given to other factors.

Contemporaneous Circumstances
Under Which Statute Was Enacted

Statutes are construed by the courts with reference to the circumstances existing at the time of passage. *U.S. v. Wise*, 370 U.S. 405, 82 S.Ct. 1354, 8 L.Ed.2d 590 (1962) (holding that, in 1890 at the time Congress enacted the Sherman [Anti-trust] Act, individuals were clearly included, under the then prevailing law, within the term *persons* who might be subject to statutory criminal liability but that "[t]he doctrine of corporate

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[8]This Honorable Court has already amply described the difference between obtaining an abortion in private consultation with one's own personal physician and obtaining one through a contract or arrangement with an abortion clinic. *See Bellotti v. Baird*, 443 U.S. 622, 641 n.21, 99 S.Ct. 3035, 3047 n.21, 61 L.Ed.2d 797 (1979).

criminal responsibility for the acts of the officers was not well established in 1890," 370 U.S. at 408, 82 S.Ct. at 1357, and that, therefore, Congress' express inclusion of corporations into the definition of *person* under the then prevailing law did not signify an intent to exclude individual corporate officers from such definition).

Accordingly, in *Beal v. Doe*, 432 U.S. 438, 97 S.Ct. 2366, 53 L.Ed.2d 464 (1977), this Honorable Court found it necessary and helpful to ascertain the then prevailing law at the time Title XIX was enacted and concluded that "when Congress passed Title XIX in 1965, nontherapeutic abortions were unlawful in most States," *id.*, 432 U.S. at 447, 97 S.Ct. at 2372, noting:

> "At the time of our 1973 decision in *Roe* [*v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973)], some eight years after the enactment of Title XIX, at least 30 States had statutory prohibitions against nontherapeutic abortions [citing 410 U.S. 113, 118 n.2, 93 S.Ct. 705, 709, 35 L.Ed.2d 147 (1973)],"

Beal, supra, 432 U.S. 477 n.12, 97 S.Ct. 2372 n.12.[9] As a result of this contemporaneous circumstance prevailing at the time of Title XIX's enactment by Congress, this Court in *Beal* held that "the provisions of the Social Security Act do not require a State, as a condition of participation, to include the funding of elective abortions in its Medicaid program," *id.*, 432 U.S. 477 n.15, 97 S.Ct. 2372 n.15, but rather allowed inclusion of such

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[9] Actually, it has been reported that, at the time of Title XIX's enactment in 1965, *forty-four* States either banned abortion or allowed it only to save the mother's life. See "Gains for Birth Control: Need for New Legislation," *Newsweek*, volume 66, December 13, 1965, at p. 94 (abortions for pregnancies which are said to endanger the mother's physical or mental health, which result from rape or incest, or which would result in a child with physical or mental defects, still too controversial for formal consideration by delegates of the American Medical Association, which voted to defer committee proposal).

abortion funding on a voluntary, optional basis with the States.[10]

This Honorable Court in *Beal* could only resolve part of the important Federal question regarding the underlying obligation of States under Title XIX to provide mandatory coverage of abortion services in their State Medicaid plans (insofar as Federal funds are also appropriated and made available for same), precisely because the State of Pennsylvania before the court in *Beal* had optionally chosen at the time to provide coverage for certain abortions which were performed for reasons other than to save the life of the mother but which were asserted to be otherwise "medically necessary"—*i.e.*, "therapeutic." Thus, there was no case or controversy (and, therefore, no jurisdiction) in *Beal* as to these abortions. These abortions were left open by this Honorable Court as "serious statutory questions," *id.*, 432 U.S. at 444, 97 S.Ct. at 2371. However, it must be emphasized that in this Honorable Court's ascertainment in *Beal* of the then prevailing law at the time of Title XIX's enactment in order to determine the true intent of Congress therein, *all* of the "nontherapeutic" abortions then banned in the thirty to forty-four States *were abortions performed for any reason other than to save the mother's life*. This contemporaneous circumstance indeed raises the "serious statutory question" that ought to be resolved by a granting of the writ of certiorari sought herein.

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[10] The *Beal* court also held that by the 1972 amendments regarding "family planning services" Congress only intended to *allow* coverage of such nontherapeutic abortions, not make it mandatory on the States. Id., 432 U.S. at 446 n.10, 97 S.Ct. at 2372 n.10. Contemporaneous with these amendments, at the 1972 Democratic National Convention, even a *minority plank* favoring abortion in the party's national platform was too controversial for the delegates and thought to court political disaster. See, for example, "Eve's Operatives: Women Delegates of the Democratic Convention," *Time*, volume 100, July 24, 1972, pp. 25-26 at p. 26 and Isabelle R. Leeds, "Women at the Democratic Convention," *Mademoiselle*, volume 76, November, 1972, pp. 84 et seq., at pp. 84-92.

Interplays of Misinterpretation

A misconception forming the underlying premise of Respondents' contentions in the courts below is that *Roe, supra,* and *Doe v. Bolton,* 410 U.S. 179, 93 S.Ct. 739, 35 L.Ed.2d 201 (1973) and their progeny somehow legislatively amended Title XIX and changed the original intent of Congress in its enactment so as to add abortion services as a mandatory item of coverage to the Title XIX statutes and to the publicly-funded Medicaid program. Thus, they contend that abortion services *were not* a mandatory item of coverage in Title XIX from the time of its enactment in 1965 up to the *Roe* and *Doe* decisions in 1973, then *were* a mandatory item of coverage in Title XIX from 1973 to 1976, and then fluctuated according to the language of the Hyde Amendments incorporated into the annual appropriation Acts thereafter. The implication is that the Hyde Amendments were substantive legislation amending and changing the *post-Roe v. Wade* meaning of Title XIX in order to put limitations on the mandatory coverage of abortions required by Title XIX after 1973. In reality, however, *Roe* and *Doe* made no substantive changes to Title XIX or to the true intent of Congress in its enactment in 1965 not to require abortion services (other than to save the mother's life) as a mandatory item of coverage, and the Hyde Amendments were merely stop-gap methods used by a Congressional majority to provide at least some measure of protection of Congress' true intent in Title XIX against misinterpretations to the contrary by a number of lower court cases.

It is submitted that the decisions in *Roe* and *Doe,* based upon a constitutional liberty interest, declared in favor of pregnant women a constitutional *privilege*—or perhaps more accurately, a constitutional *immunity*—from governmental prohibitions against a woman's private decision to have an abortion but did not find any *right* to have an abortion at government's

expense, under Title XIX or otherwise. In this regard, Wesley Newcomb Hohfeld has documented in [*Some*] *Fundamental Legal Conceptions As Applied In Judicial Reasoning*, Yale University Press, New Haven, CT (1923)—which is composed of virtually the same legal commentary found at 23 Yale L.J. 16 (1913) and 26 Yale L.J. 710 (1916)—that jurisprudential errors, aberrations, and confusion which have occurred through the years could have been avoided by respecting "[t]he great practical importance of accurate thought and precise expression as regards basic legal ideas and their embodiment in a terminology not calculated to mislead ...." 26 Yale L.J. 710-711 (1916). Many of the erroneous legal conclusions in jurisprudential history pointed to in 26 Yale L.J. 711-712 n.4 were said to have been generated by

> "[t]he fallacy [which] consists in using legal terms in a popular or metaphorical sense and yet affixing to them all the legal consequences which would attach to their use in a strictly technical sense."

Id. [quoting Lord Mansfield]. See also 23 Yale L.J. 16, 33-34 (1913). Precise meanings and usage are needed in this case in order to avoid such errors: There is, accordingly, a dispositive distinction in legal usage between what is meant by a judicially enforceable (jural) *right/duty* legal relationship and the *no-right/privilege* and *no-power* (*disability*) / *immunity* legal relationships. 23 Yale L.J. 16, 53 (1913). Under the rationale of the majority opinion(s) in *Roe* and *Doe*, an adult pregnant woman has a constitutional *immunity* from undue governmental intrusion into her decision and ability to have an abortion but does *not* have a constitutional *right* over against another's correlative *duty* to provide her with one. *See* also the explanation of *Roe v. Wade* in *Maher v. Roe*, 432 U.S. 464, 97 S.Ct. 2376, 53 L.Ed.2d 484 (1977).

Congressman Bauman (of Maryland), author of the "Bau-

man Amendment" preserving States' optional coverage of abortions under various Hyde Amendments, for example, has had occasion to explain with respect to Title XIX:

> *"I can attest as one of those supporting the Hyde amendment language throughout its deliberations and adoption in recent years that the intention has been from the beginning to restrict Federal funding and not in any way to place burdens upon the rights of the States. . . .*
>
> * * *
>
> "Well, that is the same argument that I am making. *I think it is presumptuous of the lower Federal courts to misinterpret the intent of Congress in such a way as to prevent State legislatures from enacting restrictive language against abortions.*
>
> "I would point out that there are numerous cases now covering various States of the Union, in California, Georgia, Illinois, Massachusetts, Minnesota, New Jersey, Ohio, Virginia, and West Virginia, that have already been passed upon and *then have misinterpreted the law.*"

Congressional Record, 96th Congress, December 11, 1979, p. 35426 (emphasis added).

Indeed, many of the early *post-Roe v. Wade* lower court cases adding to Title XIX a new mandatory coverage of abortion by the States after 1973 and cited as "ample case authority," *Wulff v. Singleton*, 508 F.2d 1211, 1215 (U.S. App. 8th Cir. 1975), for doing so were actually based on the kind of Equal Protection reasoning later rejected by this Honorable Court in *Maher* or otherwise based on the kinds of rationales later rejected in *Beal* and in *Harris v. McRae*, 448 U.S. 297, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980).

Substantive Legislation Within Social Security Act Dealing With Abortion and Required "Medically Necessary" Services

It is submitted that further evidence of Congress' true intent with regard to the relationship abortion has to services mandatorily required as being "medically necessary" within the meaning and application of the Social Security Act [Chapter 7 of Title 42, 42 U.S.C. §§1301 *et seq.*] is contained in Section 9 of P.L. 100-517 (App. "I-5," p. 138a-139a). At the time of this enactment, the Social Security regulations covered abortions in the Medicaid program only for the medical purpose and need of saving the mother's life. *See* 42 C.F.R. §§ 441.202 and 441.203 (App. "I-6" and "I-7," p. 139a). And the finally enacted version of Section 9, which was appended onto H.R. 3235 by amendment in the legislative process and finally altered and reworded in conference committee, provides substantively as follows:

> "With respect to abortion services, the Secretary of Health and Human Services shall not promulgate or issue any regulations, policy statements, or interpretations or develop any practices concerning the performance of medically necessary procedures if such regulations, policy statements, interpretations, or practices would be inconsistent with regulations, policy statements, interpretations, or practices in effect on the date of the enactment of this Act [Oct. 24, 1988]."

This measure was prompted by consideration of a Health Maintenance Organization (HMO) bill and an anecdotal incident involving Federal administrative approval of an HMO. Thus, Section 9 began as a broad Senate amendment to the bill:

> "MR. HUMPHREY: Mr. President, the Department of Health and Human Services has federally qualified an HMO that does not and will not provide for the performance of abortions as a medically necessary service. My

amendment would statutorily protect this HMO, the HMO's that are currently federally qualified, and future HMO's that seek to be federally qualified but choose not to provide for the performance of abortions as a medically necessary service. Is that the Senator's understanding of the amendment?

"MR. HATCH: Yes, I agree with the Senator's interpretation.

"MR. KENNEDY: I thank the Senator for his explanation. My understanding is that this amendment protects the definition of medically necessary services as currently defined in regulations, and policy statements, and as applied by current Department practices and interpretations. The Senator's amendment protects HMO's from any efforts by this and future administrations to force HMO's to provide unreasonable or anticompetitive new services. His amendment would require congress to legislate any changes in the required benefits package."

Congressional Record—Senate, August 11, 1988, p. S11751.

This amendment was rejected by the House, and a conference committee proposed the statutory language that was actually adopted. The conference committee report graphically explained the amendment process:

"4. Medically Necessary Procedures

"Present law

"HMO's are required to provide medically necessary services.

"House bill

"No provision.

"Senate amendment

"The amendment prohibits the Secretary from changing regulations, policy statements, interpretations and practices regarding the performance of medically necessary procedures that are in effect on the date of enactment.

"Conference agreement

"The agreement includes a prohibition only with respect to abortion services. Under the agreement, the Secretary would be prohibited from changing regulations, policy statements, interpretations and practices with respect to abortion services in effect on the date of enactment."

5 U.S. Code Congressional and Administrative News, 100th Congress, Second Session, pp. 3245-3246.

Although this particular section was tacked onto HMO legislation and actually began as an anecdotal episode involving an HMO, it is submitted that it evinces Congressional intent regarding abortion services as *not* being *required* "medically necessary" services within the meaning and ambit of the entire Social Security Act [Chapter 7 of Title 42, 42 U.S.C. §§1301 *et seq.*], including Title XIX thereof. *First*, the plain language of Section 9 of P.L. 100-517 is not directly aimed at only HMO's in particular but rather at the provision authorizing administrative rules and regulations for the entirety of Chapter 7 of Title 42 of the U.S. Code—*viz.*, 42 U.S.C. §1302(a) (App. "I-4," p. 138a). *Second*, it appears that the only Social Security regulation directed specifically at describing medically necessary abortion services and, therefore, the only Social Security regulation affected by this statutory provision is 42 C.F.R. §441.203 (App. "I-7," p. 139a). And *third*, the HMO program and the Medicaid program are inextricably interwoven, such

that the programs would be unworkable if the legal meaning (Congressional intent) of required "medically necessary" services under the HMO program was different from that of required "medically necessary" services under the Medicaid program, since Medicaid patients are members of HMO's and receive their Medicaid-covered medical services therefrom. *See*, for example, 42 U.S.C. §1396b(m). *Cf.* 42 C.F.R. §417.101.

Reasonableness of Louisiana's Abortion Funding Restriction

This Honorable Court has explained:

> "[N]othing in the statute [Title XIX] suggests that participating States are required to fund every medical procedure that falls within the delineated categories of medical care. Indeed, the statute expressly provides:
>
> > 'A State plan for medical assistance must . . . include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which . . . are consistent with the objectives of this (Title) . . . .' 42 U.S.C. § 1396a(a)(17) (1970 ed., Supp. V).
>
> This language confers broad discretion on the States to adopt standards for determining the extent of medical assistance, requiring only that such standards be 'reasonable' and 'consistent with the objectives' of the Act."

Beal, supra, 432 U.S. at 444, 97 S.Ct. at 2370-2371.

The statute's broadly stated purpose of furnishing medical assistance to the needy does not signal a Congressional intent to provide for public funding for abortions in particular. Abortion is not just a medical procedure like all other medical procedures; rather, as this Honorable Court has recognized, "[a]bortion is inherently different from other medical procedures, because no other procedure involves the purposeful ter-

mination of a potential life," *Harris*, 448 U.S. at 325, 100 S.Ct. at 2692. *See* also *Maher*, 432 U.S. at 480, 97 S.Ct. at 2386 ("other medical procedures . . . do not involve the termination of a potential human life"). Thus, considering the statute's silence as to abortions, Title XIX cannot reasonably be interpreted as evidencing an intent to *require* participating States to pay for abortions. *See Beal*, 432 U.S. at 446, 97 S.Ct. at 2372 ("we will not presume that Congress intended to condition a State's participation in the Medicaid program on its willingness to undercut [its] important interest [in encouraging normal childbirth] by subsidizing the costs of nontherapeutic abortions"); *Roe v. Ferguson*, 515 F.2d 279, 283 (U.S. App. 6th Cir. 1975) ("In view of the disfavor shown toward abortions in other legislation, we are reluctant to infer that Congress intended to include required coverage for such controversial services without even mentioning the subject."). *See* also *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1, 17, 101 S.Ct. 1531, 1540, 67 L.Ed.2d 694 (1981) ("if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously").

Indeed, the history of Title XIX suggests that, in establishing the Medicaid program, Congress did not intend to mandate that states subsidize abortions. When Title XIX was enacted, abortions performed for reasons other than to save the life of the mother were unlawful in most states. *See Roe v. Wade*, 410 U.S. 113, 118 n. 2, 93 S.Ct. 705, 709 n. 2, 35 L.Ed.2d 147 (1973). For that reason, among others, this Honorable Court rejected the argument advanced in *Beal, supra*, "that Congress intended to require—rather than permit—participating states to fund nontherapeutic abortions," *id.*, 432 U.S. at 447, 97 S.Ct. at 2372. For the same reason, it should be clear that Congress did not intend to require states to pay for abortions which are not necessary to save the life of the mother.

Conclusion

This case presents a compelling opportunity for this Honorable Court to resolve a conflict among the circuits and, at the same time, to settle an important Federal question seriously threatening harmonious Federal-State relationships nationwide in the delivery of truly vital medical and health care to needy persons and families in their fight against disease and physical disabilities. This Honorable Court should grant the writ petitioned for herein and take this case on review.

Respectfully Submitted,

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APPENDIX A

[Filed September 11, 1995]

HOPE MEDICAL GROUP FOR WOMEN, on behalf of itself and the Medicaid-eligible women of the State of Louisiana to whom it provides health care, and Ifeanyi Charles Okpalobi, M.D., on behalf of himself and his Medicaid-eligible patients seeking abortions, et al., Plaintiffs-Appellees,

v.

Edwin EDWARDS, Governor of the State of Louisiana, et al., Defendants-Appellants.

No. 94-30445.

United States Court of Appeals, Fifth Circuit.
Sept. 11, 1995. Rehearing Denied Oct. 17, 1995.

Before WISDOM, GARWOOD and DAVIS, Circuit Judges.

W. EUGENE DAVIS, Circuit Judge:

This appeal centers on the complex issue of public funding for abortions. The plaintiffs, Hope Medical Group for Women and Dr. Ifeanyi Okpalobi, filed suit in federal district court on behalf of their Medicaid-eligible patients seeking to enjoin Louisiana from enforcing a state statute prohibiting the state's Medicaid program from funding abortions except in cases where an abortion is necessary to save the life of the mother. The district court issued an injunction prohibiting the state from enforcing the statute in so far as the statute prohibits funding for abortions to terminate pregnancies resulting from rape or incest. The state subsequently appealed. For the reasons explained below, we affirm.

I.

The plaintiffs' suit focuses on LA-R.S. 40:1299.34.5, which prohibits Louisiana's state Medicaid program from offering abortions except when necessary to save the life of the mother.

They contend that this restriction violates Title XIX of the Social Security Act and the 1994 version of the so-called Hyde Amendment. Title XIX establishes the Medicaid program, a jointly funded federal-state program designed to provide medical care for qualified individuals "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396. States choosing to participate in the program receive federal funds appropriated under Title XIX and use these funds to finance the health care of state residents who meet the eligibility criteria set forth in the Act.

Although a state's participation in the Medicaid program is voluntary, participating states must abide by the requirements imposed by Title XIX and regulations issued by the Health Care Finance Administration (the "HCFA"), which is the federal agency created by the Act to administer the Medicaid program. *See Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498, 502, 110 S.Ct. 2510, 2513-14, 110 L.Ed.2d 455 (1990). Title XIX enumerates eight broad categories of medical services that state programs must provide to individuals classified as "categorically needy":[1]

(1) inpatient and outpatient hospital services;
(2) other laboratory or X-ray services;
(3) nursing facility services;
(4) early and periodic screening, diagnostic and treatment services for recipients under the age of 21;
(5) family planning services and supplies;
(6) physicians' services and services furnished by a dentist;
(7) services furnished by a nurse-midwife;
(8) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner.

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[1] 42 U.S.C. § 1396a(a)(10) sets forth the eligibility criteria for determining whether an individual is "categorically needy."

42 U.S.C. § 1396d(a).

The obligation of participating states to provide abortion services under Title XIX are circumscribed, however, by the so-called Hyde Amendment. In 1976, congress enacted the first version of the Hyde Amendment as a rider to an appropriations bill. The Hyde Amendment restricted the use of federal funds for abortion services under Title XIX. Although the specific language and scope of the Hyde Amendment changed over the years, the version in force until 1981 essentially limited funding for abortions to three cases: (1) where the mother's life was in danger, (2) where the abortion was to terminate a pregnancy resulting from rape or incest, and (3) where "severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term." *See* Pub.L. 95-205, 91 Stat. 1460 (Dec. 9, 1977).

From 1981 until 1993, Congress enacted an even stricter version of the Hyde Amendment which prohibited federal funds for abortions "except where the life of the mother would be endangered if the fetus were carried to term." *See* eg. Pub.L. No. 101-166, 103 Stat. 1159, 1177 (1989). Louisiana's abortion funding restriction mirrors the 1981-1993 version of the Hyde Amendment. The Louisiana provision provides that:

> Notwithstanding any other provision of law to the contrary, no public funds, made available to any institution, board, commission, department, agency, official, or employee of the state of Louisiana, or of any local political subdivision thereof, whether such funds are made available by the government of the United States, the state of Louisiana, or of a local governmental subdivision, or from any other public source shall be used in any way for, to assist in, or to provide facilities for an abortion, *except when the abortion is medically necessary to prevent the death of the mother.*

LA-R.S. 40:1299.34.5 (emphasis added).

In 1993, Congress enacted a new version of the Hyde Amendment which, for the first time since 1981, permitted federal funds to be used for abortions to terminate pregnancies resulting from rape or incest. Pub.L. No. 103-112, 107 Stat. 1082 (1993). The 1994 version of the Hyde Amendment thus expanded the availability of funds for abortions under Title XIX. However, because Louisiana retained its restrictive abortion funding ban, the state's Medicaid program could not fund abortions in rape and incest cases even though federal funds were available under the 1994 version of the Hyde Amendment. The plaintiffs subsequently filed the present suit, arguing that Louisiana's abortion funding restriction violates Title XIX and the 1994 Hyde Amendment.

After a hearing, the district court ruled in favor of the plaintiffs and enjoined the state from enforcing LA-R.S. 40:1299.34.5's ban on funds for abortions in rape and incest cases as long as the state receives federal funds under Title XIX. The court held that the 1994 Hyde Amendment substantively modified states' obligations under Title XIX and that Congress' intent in enacting the Hyde Amendment "was to ensure that states fund abortions in those narrow circumstances where federal funds were available under the Hyde Amendments." *Hope Medical Group v. Edwards*, 860 F.Supp. 1149, 1152 (E.D.La.1994). The court concluded that LA-R.S. 40:1299.34.5 conflicts with Title XIX "as amended" by the Hyde Amendment because it does not "provide Medicaid reimbursement to eligible women who have abortions terminating pregnancies resulting from rape or incest." *Id.* at 1154. The state timely appealed from the court's judgment enjoining the state from enforcing its abortion funding restrictions. Before addressing the merits of the district court's decision, however, we must first address whether a recent amendment to Louisiana's abortion funding statute moots this appeal.

II.

During a special legislative session following the district court's order enjoining enforcement of LA-R.S. 40:1299.34.5, the Louisiana legislature amended the provision. The amended provision permits public funds for abortions in cases of rape and incest as well as in cases where the abortion is needed to save the life of the mother. *See* LA-R.S. 40:1299.34.5(B). Although the parties' briefs on appeal do not address whether the amendment moots this appeal, one of the plaintiffs, Dr. Okpalobi, raised the mootness issue in a motion to dismiss the appeal and again during oral argument. Because the presence of a live case or controversy is a threshold jurisdictional requirement, we must address it even if it is not raised by the parties.

A case is moot for Article III purposes if the issues presented are no longer live or the parties lack a legally cognizable interest in the outcome. *See Campanioni v. Barr*, 962 F.2d 461 (5th Cir.1992). An exception to the mootness doctrine exists in cases where a controversy is likely to recur, but may evade review. *See Henschen v. City of Houston*, 959 F.2d 584 (5th Cir.1992). After reviewing the amended version of LA-R.S. 40:1299.34.5, we conclude that the present case falls within this exception to the mootness doctrine.

The amended version of the funding restriction provides that public funding for abortions in rape and incest cases will only be available so long as "a decision or order of a court of competent jurisdiction" declares that the original version of the statute violates Title XIX. LA-R.S. 40:1299.34.5. The amended restriction thus allows abortion funding in rape and incest cases only if a court order continues to compel the state to do so. *Id.* Upon dissolution of the court order, the provision's exception for rape and incest cases becomes inapplicable and the original restriction prohibiting publicly-funded

abortions except in cases where the mother's life is in danger becomes effective. *Id.* [2] The amended provision further provides that state officials "shall vigorously and expeditiously pursue judicial remedies seeking to obtain . . . reversal" of any order compelling the state to fund abortions in rape and incest cases. *See* LA-R.S. 40:1299.34.5.

The language of the revised statute clearly indicates that the Louisiana legislature amended the state's abortion funding restriction so that it could bring its Medicaid program into compliance with the district court's injunction. The conditional language of the statute and the language directing state officials to seek a reversal of the injunction reveal the continued presence of a live controversy between the parties over the validity of LA-R.S. 40:1299.34.5. In *City of Mesquite v. Aladdin's Castle, Inc.*, 455 U.S. 283, 289, 102 S.Ct. 1070, 1074-75, 71 L.Ed.2d 152 (1982), the Supreme Court held that the repeal of a city ordinance struck down as a violation of the First Amendment did not moot the appeal because "the city's repeal of the objectionable language would not preclude it from reenacting precisely the same provision" if the lower court's order enjoining the city from enforcing the ordinance was ever vacated. In the present case, the plain language of the LA-R.S. 40:1299.34.5(D) manifests the state's intent to deny abortions in rape and incest cases as soon as the district court's injunction can be vacated. Given the state's power to reenact the original version of its funding restriction and its stated intent to do so, we conclude that this appeal is not moot. We therefore turn to the merits of the district court's injunction.

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[2] The amendment divides the statutory restriction into two parts. Part A contains the original restriction prohibiting abortions except where the mother's life is in danger. Part B permits abortions in rape and incest cases. Part B of the statute is triggered only upon the entry of a court order holding Part A invalid. Once the court order is dissolved, Part B becomes ineffective.

III.

The plaintiffs raise essentially two arguments in support of the district court's injunction against the Louisiana abortion funding restriction. First, they contend that the 1994 version of the Hyde Amendment independently requires states to fund all abortions permitted by the amendment. Second, they alternatively argue that LA-R.S. 40:1299.34.5 violates Title XIX and its accompanying regulations because the provision unreasonably prohibits abortions without regard to medical necessity. We will consider both arguments in turn.

A.

The plaintiffs first contend that the 1994 Hyde Amendment substantively amends Title XIX by requiring state Medicaid programs to cover all abortions in the two categories of cases enumerated in the amendment: (1) abortions required to save the life of the mother, and (2) abortions to terminate pregnancies resulting from rape or incest. The plaintiffs' reading of the 1994 Hyde Amendment essentially eliminates the discretion of state Medicaid programs to place limitations on abortion services in cases of rape or incest and in cases where an abortion is necessary to save the life of the mother.

The plaintiffs' argument relies primarily on the legislative history of the Hyde Amendment. During the congressional floor debates preceding the passage of the 1994 Hyde Amendment, several legislators stated that a proposal to eliminate the amendment would result in states having to fund non-therapeutic abortions. For example, Senator Nickels explained that a repeal of the Hyde Amendment "would result in mandating that states pay for these abortions with state dollars." 139 Cong.Rec. S12,581 (Sept. 28, 1993). Likewise, Senator Hatch argued that "every state will be required to provide matching funds for abortion on demand" if the Hyde Amendment were repealed. *Id.* at S12,588. According to the plaintiffs, these state-

ments reveal Congress' understanding that states must fund all abortions for which federal funds are available.

The plaintiffs also point to the absence of the so-called "Bauman Amendment" language in the 1994 version of the Hyde Amendment. The Bauman Amendment was originally added to the 1979 version of the Hyde Amendment, and provided that "the several states are and shall remain free not to fund abortions to the extent that they in their sole discretion deem appropriate." The plaintiffs argue that the absence of this provision in the current version of the Hyde Amendment demonstrates that Congress intended to make Medicaid funding of abortions covered under the Hyde Amendment mandatory, and thus remove the states' discretion to limit abortion services provided through their Medicaid programs.

The defendants counter by arguing that the Hyde Amendment does not impose any independent substantive obligations on state Medicaid programs apart from Title XIX. They read the Hyde Amendment as a mere appropriations provision that restricts the use of federal funds for abortions except under limited circumstances. They argue that the amendment is purely permissive with regard to state funding of abortions under the two exceptions where federal funds are permitted by the Hyde Amendment.

Most of the cases interpreting the Hyde Amendment have generally focussed on whether the Hyde Amendment relieves state Medicaid programs of Title XIX's requirements with respect to abortions for which federal funding is not available under the amendment. *See Preterm, Inc. v. Dukakis*, 591 F.2d 121, 125 (1st Cir.1979); *Roe v. Casey*, 623 F.2d 829 (3rd Cir.1980); *See also Harris v. McRae*, 448 U.S. 297, 309, 100 S.Ct. 2671, 2684, 65 L.Ed.2d 784 (1980) ("Title XIX does not require a participating State to include in its plan any services for which a subsequent Congress has withheld federal funding."). However, in *Hern v.*

Beye, 57 F.3d 906 (10th Cir.1995), the Tenth Circuit addressed the converse question of whether the Hyde Amendment independently imposes an obligation on participating states to fund all abortions permitted by the amendment. The court concluded that the Hyde Amendment does not impose substantive obligations on State Medicaid programs:

> [T]he Hyde Amendment does not affect the states' underlying obligations imposed by Title XIX and federal Medicaid regulations. That is, although the Hyde Amendment relieves states' of having to fund abortions for which federal funding is unavailable, it does not alter states' obligations with respect to abortions for which federal funding is available.

Id. at 909 (emphasis in original). The court reasoned that state restrictions on abortion funding must be evaluated with reference to the requirements of Title XIX and its accompanying regulations, not the Hyde Amendment. *Id.*

We agree with the Tenth Circuit that the Hyde Amendment does not impose any independent obligations on states apart from the requirements of Title XIX. The plain meaning of a statute's language governs its construction unless so doing would clearly violate congressional intent or lead to absurd results. *See United States v. Rodriguez-Rios*, 14 F.3d 1040, 1044 (5th Cir.1994).

Turning to the language of the Hyde Amendment and the case law applying the amendment, we agree with the defendants' argument that the Hyde Amendment does not create substantive obligations. On its face, the Hyde Amendment merely restricts the use of federal funds for abortions. The 1994 version of the amendment provides:

> None of the funds appropriated under this Act shall be expended for any abortion except when it is made

> known to the Federal entity or official to which funds are appropriated under this Act that such procedure is necessary to save the life of the mother or that the pregnancy is the result of an act of rape or incest.

Pub.L. No. 103-112, 107 Stat. 1082 (1993). Although the 1994 version of the Hyde Amendment permits the use of federal funds for abortions in rape and incest cases, the amendment contains no language obligating state Medicaid programs to fund abortions under these circumstances. Nor does the amendment purport to substantively amend Title XIX with respect to the authority of state Medicaid programs to tailor the scope of their medical coverage.

Neither the Hyde Amendment's legislative history nor the absence of the Bauman Amendment language persuade us to abandon the plain meaning of the statute. The excerpts of the congressional debate cited by the plaintiffs focussed on the implications of a proposal to remove the Hyde Amendment from the 1994 appropriations bill for health and human services programs. When viewed in this context, these statements appear merely to reflect the fear of the Hyde Amendment's proponents that a defeat of the amendment would result in states having to fund all medically necessary abortions under Title XIX. These statements focus on states' obligations *under Title XIX*, not whether the Hyde Amendment imposes independent obligations on state Medicaid programs. They do not, therefore, suggest that the Hyde Amendment's language restricting abortion funding can be read to conversely require states to provide abortions permitted by the amendment.

We also disagree that the absence of the so-called Bauman Amendment similarly dictates that we abandon the plain meaning of the Hyde Amendment. During the Congressional debates preceding the passage of the Bauman Amendment in 1979, Representative Bauman explained that the intent of the

Bauman Amendment was to modify states' obligations under Title XIX and to grant participating states the authority to eliminate abortion services from their Medicaid programs. Cong.Rec. 25425-35426 (Dec. 11, 1979). Thus, as with the debates over the Hyde Amendment, the debates over the Bauman Amendment centered on the obligations imposed by Title XIX, not the Hyde Amendment. Indeed, Representative Bauman explained that the purpose of the Hyde Amendment "has been from the beginning to restrict Federal funding and not in any way to place burdens on the rights of States." *Id.* at 35426.

We therefore follow *Hern* in holding that the Hyde Amendment does not create any independent obligations on states participating in the Medicaid Program to fund abortions permitted by the amendment. Accordingly, we must now turn to the text of Title XIX and its accompanying regulations to determine whether the Louisiana funding restriction violates these requirements.

B.

Whether Louisiana's funding restriction violates Title XIX turns on the extent to which the Act affords participating states the discretion to place restrictions on the medical services offered through their Medicaid programs. Although Title XIX does not specifically include abortion as a mandatory service, the parties concede that abortion services fall under several of the eight broad categories of medical services mandated by the Act, including inpatient hospital services, outpatient hospital services, physician's services, and family planning services. *See* 42 U.S.C. § 1396d(a). The plaintiffs contend that abortion services are therefore mandated by Title XIX and that Louisiana's funding restriction violates the Act because it generally prohibits abortions except in cases where the mother's life is in danger.

Title XIX "confers broad discretion on the states to adopt

standards for determining the extent of medical assistance" provided through their Medicaid programs. *Beal v. Doe*, 432 U.S. 438, 444, 97 S.Ct. 2366, 2371, 53 L.Ed.2d 464 (1977). However, states' discretion to limit the scope of the medical services offered through their Medicaid programs is subject to important restrictions. Title XIX specifically provides that participating states must establish "reasonable standards" that are "consistent with the objectives" of the Act. 42 U.S.C. § 1396a(a)(17). Some courts have read this provision as mandating that states must cover all medical procedures certified as "medically necessary" by a recipient's physician. See *Weaver v. Reagen*, 886 F.2d 194 (8th Cir.1989); *Pinneke v. Preisser*, 623 F.2d 546, 548 n. 2 (8th Cir.1980). Other courts have declined to impose such a strict "medical necessity" restriction on states' discretion. Instead, they read Title XIX as granting states some discretion to limit medical services based on their judgment as to whether a particular medical service is medically necessary. *See Preterm*, 591 F.2d at 125. [3] Under this approach, a state program's decision to limit a service based on the degree of medical necessity is subject only to Title XIX's requirement that the limitation must be reasonable. *Id.*

HCFA regulations promulgated under Title XIX provide additional guidance in assessing the reasonableness of a state restriction on the medical services offered through its Medicaid program. These regulations provide that:

(b) Each [medical] service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

(c) The Medicaid agency may not *arbitrarily* deny or reduce

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[3] In *Preterm*, the court rejected the argument that a state Medicaid program must cover any medical procedure certified by a doctor as medically necessary. Rather, the court reasoned that state legislatures may make "the macro-decision . . . that only certain kinds of medical assistance are deemed sufficiently necessary to come under the coverage of its plan." Id. at 125.

the amount, duration, or scope of a required service . . . to an otherwise eligible recipient *solely because of the diagnosis, type of illness or condition.*

(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

42 C.F.R. § 440.230 (emphasis added). A participating state may, therefore, choose to limit the provision of particular medical procedures or treatments as long as the restriction complies with § 440.230.

Almost all the federal circuit cases addressing whether state abortion funding restrictions violate Title XIX have held that state restrictions similar to LA-R.S. 40:1299.34.5 violate Title XIX. *See Preterm*, 591 F.2d at 125; *Casey*, 623 F.2d 829; *Hodgson v. Board of County Comm'rs, County of Hennepin*, 614 F.2d 601, 608 (8th Cir.1980); *Zbaraz v. Quern*, 596 F.2d 196, 199 (7th Cir.), cert. denied, 448 U.S. 907, 100 S.Ct. 3048, 65 L.Ed.2d 1136 (1980); *Hern*, 57 F.3d at 909-10; *Little Rock Family Planning Services v. Dalton*, 60 F.3d 497 (8th Cir.1995). [4] In many of these cases, the state abortion funding restrictions were actually less restrictive than LA-R.S. 40:1299.34.5 because they allowed funds for abortions in cases of rape or incest. Although each of these courts offer slightly different rationales for holding the restrictions invalid, they each generally arrive at the same conclusion: the state restrictions were inconsistent with the basic objective of Title XIX to provide necessary medical services to eligible recipients.

In Preterm, the First Circuit struck down a Massachusetts

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[4] Recent federal district court decisions have similarly held that such restrictions are invalid. *See Planned Parenthood v. Wright*, No. 94 C 6886, 1994 WL 750638 (N.D.Ill. Dec. 6, 1994); *Planned Parenthood v. Engler*, 860 F.Supp. 406 (W.D.Mich.1994); *Planned Parenthood v. Blouke*, 858 F.Supp. 137 (D.Mont.1994).

abortion funding restriction that was less restrictive than the Louisiana restriction at issue in this case. The Massachusetts statute prohibited the state Medicaid program from funding abortions except in cases where the mother's life was in danger and where the pregnancy resulted from rape or incest. 591 F.2d at 126-127. The plaintiffs in *Preterm* argued that the state's funding restriction violated Title XIX because it did not permit funding for abortions in cases where the health of the mother was at risk. [5]

Although the First Circuit acknowledged that the state's abortion funding restriction was arguably a limitation based on medical necessity, the court concluded that restrictions which limit medical services "to life and death situations" and cases of rape and incest contravene the objectives of the Act. *Id.* According to the court, the state funding restriction contravened the objectives of Title XIX in two respects. First, the court reasoned that Title XIX's objective of providing needed medical care is broader than the stark "life and death" restriction embodied in the Massachusetts provision. The court concluded that the state's restriction thus "crossed the line between permissible discrimination based on degree of need and entered into forbidden discrimination based on medical condition." *Id.* at 126. The court further held that the restriction contravened Title XIX by failing to incorporate physician input into whether or not a given abortion procedure is medically necessary. According to the court, Title XIX "provides for a central role for the physician in determining proper treatment." *Id.* at 127.

In *Hodgson*, the Eighth Circuit similarly held that a Minnesota statute limiting Medicaid-funded abortions was in-

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[5] At the time, the Hyde Amendment permitted funds to be used for abortions in cases where the mother would suffer severe and long-lasting physical damage if forced to carry the pregnancy to term. *See* Pub.L. 95-205, 91 Stat. 1460 (Dec. 9, 1977).

valid. 614 F.2d at 608. As with the Massachusetts statute, the Minnesota statute limited abortions offered through its Medicaid program to cases where the abortion was necessary to save the life of the mother and in cases of rape or incest. The court concluded that Minnesota's funding restriction was arbitrary because the state's Medicaid program subsidized "health-sustaining" services in general, but, in the case of abortion, subsidized abortion procedures only if they were "life-sustaining." *Id.* The court concluded that the state's restriction on abortion funding was thus "not in accordance with a uniform standard of medical need." *Id.*

Both Preterm and Hodgson were decided against the backdrop of the pre-1981 version of the Hyde Amendment, which, like the 1994 version of the amendment, permitted federal funding for abortions in cases of rape and incest. The Tenth Circuit, however, recently addressed this precise issue against the backdrop of the 1994 version of the Hyde Amendment. In *Hern*, the court ruled that a Colorado statute contravened Title XIX because it restricted abortions provided through the state's Medicaid program to cases where an abortion was necessary to save the life of the mother. Like the Louisiana abortion funding restriction, the Colorado restriction did not provide funds for abortions in cases of rape or incest. The court held that the statute contravened Title XIX because it "categorically denies coverage for a specific, medically necessary procedure except in those rare instances when a patient's life is at stake." *Id.* at 911. The court reasoned that this restriction was antithetical to a basic objective of Title XIX—"to provide necessary medical services to qualified individuals." *Id.* at 910-11. Therefore, *Hern* essentially tracks the reasoning of *Hodgson* and *Preterm* in holding that the Colorado funding restriction violated Title XIX because it was an arbitrary restriction based solely on a recipient's condition or diagnosis.

We agree with the reasoning of these decisions and hold

that Louisiana's abortion funding restriction similarly violates Title XIX. The text of Title XIX reveals that the Medicaid program is not limited to merely providing medical services necessary to save patients' lives. Title XIX contains no language suggesting that the medical services mandated by the Act are mandatory only in life and death situations. Indeed, Title XIX specifically requires participating states to provide preventive medical services, such as prenatal care, dental care, and "periodic screening, diagnostic and treatment services" for eligible recipients under age 21. *See* 42 U.S.C. § 1396d(a)(4)-(5). Title XIX also requires state Medicaid programs to provide outpatient hospital services. *See* 42 U.S.C. § 1396d(a)(2)(A). That Title XIX requires states to provide medical services not typically associated with life and death situations manifests the broad scope of the program. As noted in *Hodgson*, the broad objective of Title XIX is to provide "health-sustaining" medical services to eligible recipients, not merely "life-sustaining" services. 614 F.2d at 608.

Given the broad scope of Title XIX, Louisiana's funding restriction is inconsistent with the objectives of the Act because the restriction categorically limits abortions offered through the state's Medicaid program to life and death situations without regard to the medical necessity of abortions in rape and incest cases. During the hearing, the plaintiffs produced evidence supporting their claim that abortions in rape and incest cases are often medically necessary even though the mother's life might not be in danger. The plaintiffs' evidence included research reports and expert testimony detailing the mental and physical health problems attendant to pregnancies resulting from rape or incest. The plaintiffs also introduced a December 1993 letter sent by the HCFA to the directors of each state Medicaid program. The letter stated that, in the opinion of the HCFA, Title XIX now requires participating states to fund medically necessary abortions in rape and incest cases because

of the expansion of funding under the 1994 version of the Hyde Amendment. This language suggests that, in at least some cases, abortions in cases of rape or incest are medically necessary and must therefore be provided by state Medicaid programs under Title XIX. [6]

The defendants failed to controvert the plaintiffs' evidence that abortions in rape and incest cases are frequently medically necessary. Indeed, the defendants do not dispute the plaintiffs' argument that Louisiana's abortion funding restriction is not grounded on the health or medical needs of Title XIX patients. Although Title XIX and 42 C.F.R. § 440.230 allow state Medicaid programs to adopt appropriate limits based on medical necessity, such restrictions must be consistent with the Act's objective of providing a broad range of health-sustaining services. For example, restrictions that limit the provision of medical services to life and death cases may be appropriate where the medical benefits of certain procedures or treatments are significantly outweighed by their risks to patients' health. Such a restriction would be consistent with promoting the health of Title XIX patients. Restrictions might also be appropriate where the state legislature or the state Medicaid program determines that a medical treatment or procedure is not medically necessary. *See Preterm*, 591 F.2d at 125. [7] However,

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[6] The HCFA letter also suggests that abortions in rape and incest cases are "per se" medically necessary and, therefore, must be provided by states without restriction. We need not, however, decide whether this language in the HCFA directive purports to totally eliminate states' discretion to restrict abortions in rape and incest cases. Regardless of whether the directive can be read to eliminate states' discretion over abortions in rape and incest cases, Louisiana's restriction violates Title XIX because it categorically limits Medicaid-funded abortions to life and death situations

[7] *See also Mother Doe et al. v. Stewart*, No. 74-3197 (E.D.La. Feb. 20, 1976) (Ainsworth, J.). In *Mother Doe*, a three judge district court upheld a Louisiana statute that prohibited "non-therapeutic" abortions. The court

the defendants offer no grounds for concluding that abortions in rape and incest cases are never medically necessary.

We also disagree with the defendants' contention that Louisiana's interest in encouraging childbirth over abortion is sufficient to sustain the state's abortion funding restriction. The defendants' argument relies primarily on language taken from *Beal*, 432 U.S. at 445-446, 97 S.Ct. at 2371-2372. In *Beal*, the Supreme Court upheld a state statute that prohibited the state's Medicaid program from offering *non-therapeutic* abortions. The court reasoned that states had a legitimate interest in encouraging childbirth, and that this interest is sufficiently compelling to support state restrictions on Medicaid funding for non-therapeutic abortions:

> The respondents point to nothing in either the language or the legislative history of Title XIX that suggests that it is unreasonable for a participating State to further this unquestionably strong and legitimate interest in encouraging normal childbirth. Absent such a showing, we will not presume that Congress intended to condition a State's participation in the Medicaid program on its willingness to undercut this important interest by subsidizing the costs of non-therapeutic abortions.

Id. at 446, 97 S.Ct. at 2371. The defendants contend that the Court's reasoning in *Beal* supports Louisiana's funding restriction even though, unlike the restriction in *Beal*, the Louisiana provision also prohibits *therapeutic* abortions except in cases where the mother's life is in danger.

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held that a state can, consistent with Title XIX, prohibit abortions that are not medically necessary: [I]n view of Congress' recognition of a State's limited resources, its attitude toward abortions and its silence on the subject, we believe that Congress did not intend that States should pay for non-medically necessary abortions as necessary medical expenses when States are not required to fund other medically non-necessary services such as elective cosmetic surgery.

Although we agree that Louisiana's interest in encouraging normal childbirth is legitimate and supports restrictions on non-therapeutic abortions, we do not agree that this interest is sufficient to sustain the state's present abortion funding restriction. As we previously explained, one of the principal objectives of Title XIX is the provision of necessary medical services to eligible recipients. A state cannot, therefore, adopt an abortion funding restriction based solely on its interest in encouraging childbirth without taking the medical necessity of the procedure into account.

In sum, we conclude that LA-R.S. 40:1299.34.5 violates the requirements of Title XIX because it categorically prohibits funding for abortions in cases of rape or incest without regard to whether the procedures might be medically necessary. The defendants offer no medical basis for restricting abortions to life and death situations, nor do they contest the plaintiffs' position that abortions in rape and incest cases are often medically necessary. The state's abortion funding restriction is therefore inconsistent with the broad objective of Title XIX to provide needed medical care to qualified recipients. Accordingly, the district court did not err in enjoining the state from enforcing LA-R.S. 40:1299.34.5 as long as the state receives funds under Title XIX.

IV.

For the reasons stated above, we AFFIRM the district court's order enjoining the defendants from enforcing LA-R.S. 40:1299.34.5's ban on funds for abortions in rape and incest cases as long as the state receives federal funds under Title XIX.

AFFIRMED.

GARWOOD, Circuit Judge, concurring:

I concur in Judge Davis's thoughtful and well-crafted opinion, and append this writing merely to underscore my un-

derstanding as to what we do not hold or opine respecting in two particular areas.

While I agree that Louisiana's "unquestionably strong and legitimate interest in encouraging normal childbirth," *Beal v. Doe*, 432 U.S. 438 at 446, 97 S.Ct. 2366 at 2371 (1977), is not sufficient justification for the State, as a Title XIX participant, to categorically deny abortion funding to all Medicaid-eligible patients who are victims of rape or incest "without taking the medical necessity of the procedure into account" (majority op. p. 5687), I believe that interest may properly be taken into account by the state in determining the character and degree of medical necessity, in cases where the mother's life is not at stake, which will be required in order to justify provision of abortion services. In other words, the interest in preserving human life is a rational justification for a participating state to require greater and more concrete and verifiable medical necessity in cases of abortion than in cases of procedures which do not terminate human life. I do not understand Judge Davis's opinion to hold or opine to the contrary. Nor do I understand us to address the question of just what character or degree of medical necessity and demonstration thereof a participating state may lawfully require before funding an abortion for a Medicaid-eligible patient whose pregnancy results from rape or incest.[1]

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[1] The three-judge court in *Mother Doe et al. v. Stewart*, No. 74-3197 (E.D.La. Feb. 20, 1976), held that Louisiana's then policy of providing abortion funding for Medicaid-eligible patients only where either necessary to save the mother's life or "necessary to prevent serious and permanent impairment to the physical health of the mother" was "consistent with the Social Security Act" (id. at 16, 17). *Mother Doe* was summarily "affirmed" by the Supreme Court. *Doe v. Stewart*, 433 U.S. 901, 97 S.Ct. 2963, 53 L.Ed.2d 1086 (1977) (per curiam; Justices Brennan, Marshall, and Blackmun dissenting). The Supreme Court jurisdictional statement of the plaintiffs-appellants in *Doe v. Stewart* lists as the second of the two "Questions Presented," "Does the Med-

Second, the State of Louisiana in this appeal has taken an essentially all or nothing position, namely that it is entitled to participate in Title XIX while at the same time declining to ever provide Medicaid-eligible patients any funding for any abortions save only those necessary to save the mother's life. The State's only complaint of the district court's decree is that the decree conflicts with this supposed right of the State. We are thus not faced with issues of the kind raised by Judge Bowman's well-reasoned dissent in respect to the form of the district court's decree in *Little Rock Family Planning Services v. Dalton*, 60 F.3d 497 (8th Cir.1995). The form of the decree here has not been put in issue on this appeal, [2] and I do not understand Judge Davis's opinion to address that matter.

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icaid policy of the State of Louisiana, which provides payment for only therapeutic abortions, as defined by state law, violate the requirements of the Social Security Act of 1935, as amended?", and explains that "the Louisiana Medicaid Program would not pay for [plaintiff-appellant] Jane Doe's abortion because her pregnancy had not been medically determined to be seriously threatening to her life or her physical health." *Mother Doe* involved an unmarried minor's pregnancy not claimed to have resulted from rape or incest.

[2] All the State has placed in issue on this appeal is the claim that LA.R.S. 40:1299.34.5's restriction of any abortion funding to instances where necessary to save the mother's life is wholly valid notwithstanding Louisiana's continued participation in Title XIX.

APPENDIX B

HOPE MEDICAL GROUP FOR WOMEN, on behalf of itself and the Medicaid-eligible women of the State of Louisiana to whom it provides health care; Ifeanyi Charles Okpalobi, M.D., on behalf of himself and his Medicaid-eligible patients seeking abortions; and Zora H. (a pseudonym), on behalf of herself

v.

Edwin EDWARDS, Governor of the State of Louisiana, Richard Ieyoub, Attorney General of the State of Louisiana; Rose Forrest, Secretary of the Louisiana Department of Health and Hospitals; in their official capacities and their successors.

Civ. A. No. 94-1129.

United States District Court,
E.D. Louisiana.
July 28, 1994.

REASONS FOR JUDGEMENT

LIVAUDAIS, District Judge.

Plaintiffs Hope Medical Group for Women, on behalf of itself and the Medicaid-eligible women of the State of Louisiana to whom it provides health care, Ifeanyi Charles Okpalobi, M.D., on behalf of himself and his Medicaid-eligible patients seeking abortions, and Zora H., on behalf of herself, have filed a motion for a preliminary injunction prohibiting defendants from enforcing LSA-R.S. 40:1299.34.5, and ordering defendants immediately to reimburse the cost of plaintiff Zora H.'s abortion. Defendants Louisiana Governor Edwin Edwards, Louisiana Attorney General Richard Ieyoub, and Louisiana Secretary of the Department of Health and Hospitals Rose Forrest oppose the motion.

At the hearing, which was scheduled and notice afforded to all interested parties, plaintiffs Hope Medical Group for Women ("Hope") and Zora H. requested that trial of the action on the merits be advanced and consolidated with the hearing on the preliminary injunction. Rule 65(a)(2) of the Federal Rules of Civil Procedure provides that "[b]efore or after the commencement of the hearing of an application for a preliminary injunction, the court may order the trial of the action on the merits to be advanced and consolidated with the hearing of the application." *Federal Civil Judicial Procedure and Rules*, 1994 Edition (West 1994). Counsel for Dr. Ifeanyi Okpalobi and for all defendants had no objection and agreed to the consolidation, so the Court ordered the consolidation of trial on the merits with the hearing on the preliminary injunction.

Louisiana Revised Statute s 40:1299.34.5 provides:

> Notwithstanding any other provision of law to the contrary, no public funds, made available to any institution, board, commission, department, agency, official, or employee of the State of Louisiana, or of any local political governmental subdivision, or from any other public source shall be used in any way for, to assist in, or to provide facilities for an abortion, except when the abortion is medically necessary to prevent the death of the mother.

LSA-R.S. 40:1299.34.5 (West 1994). Plaintiffs argue that because this statute conflicts with Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, *et seq.*, establishing Louisiana's Medicaid program, the statute must be invalidated. *See, King v. Smith*, 392 U.S. 309, 88 S.Ct. 2128, 20 L.Ed.2d 1118 (1968) and *Planned Parenthood Association of Utah v. Dandoy*, 810 F.2d 984, 988 (10th Cir.1987).

Title XIX establishes state medicaid programs to cover the cost of medical services for low income persons in states par-

ticipating in the program. While state participation is not mandatory, those states who do participate must comply with federal statutory and regulatory requirements. *Wilder v. Virginia Hospital Association*, 496 U.S. 498, 500, 110 S.Ct. 2510, 2513, 110 L.Ed.2d 455 (1990); *St. Tammany Parish Hospital Service District v. DHHR*, 677 F.Supp. 455, 457 (E.D.La.1988). Under Title XIX, certain services are mandatory and must be covered by the state Medicaid program and others are optional. Mandatory services which must be offered include:

> (1) inpatient hospital services ...; (2) outpatient hospital services ...; (3) other laboratory and x-ray services; (4)(A) nursing facility services ...; (B) early and periodic screening, diagnostic and treatment services ... for individuals ... under the age of 21; (C) family planning services ...; (5)(A) physicians' services furnished by a physician.

42 U.S.C. § 1396d(a)(1)-(5). Each state's Medicaid plan must cover those mandatory covered services which an individual patient's physician certifies are "medically necessary." *See, e.g., Weaver v. Reagen*, 886 F.2d 194, 200 (8th Cir.1989).

Medicaid covered all medically necessary abortions between 1973 and 1976. The Hyde Amendment was passed by Congress in 1976, prohibiting federal reimbursement for abortions except in those narrow circumstances where Congress defines the abortions to be "medically necessary." *Harris v. McRae*, 448 U.S. 297, 100 S.Ct. 2671, 65 L.Ed.2d 784, *reh'g denied*, 448 U.S. 917, 101 S.Ct. 39, 65 L.Ed.2d 1180 (1980). Every year the Hyde Amendment is added to appropriation bills to fund the United States Department of Health and Human Services, the Department which administers Title XIX and Social Security. Abortion funding was limited to those circumstances when the life of the pregnant woman would be threatened by carrying the pregnancy to term between fiscal years 1982 and 1993.

The Hyde Amendment for 1994, included in the appropriations bill for the U.S. Departments of Labor, Health and Human Services, and Education, and related agencies, provides: None of the funds appropriated under the Act shall be expended for any abortion except when it is made known to the Federal entity or official to which funds are appropriated under this Act that such procedure is necessary to save the life of the mother or that the pregnancy is the result of an act of rape or incest. Pub.L. No. 103-112 § 509 (1993). Plaintiffs argue that LSA-R.S. 40:1299.34.5 conflicts with the 1994 Hyde Amendment and that its enforcement should be enjoined. Under the Supremacy Clause of the United States Constitution, state laws conflicting with federal program requirements are invalid. *Townsend v. Swank*, 404 U.S. 282, 285-286, 92 S.Ct. 502, 505, 30 L.Ed.2d 448 (1971); *Planned Parenthood Association of Utah v. Dandoy*, 810 F.2d 984, 988 (10th Cir.1987).

Several federal appellate and district courts have examined this identical issue with respect to Medicaid abortion reimbursement laws of other states. The question raised in cases decided by the Third Circuit, the Eighth Circuit, the Seventh Circuit and the First Circuit was whether states must fund abortions under their Medicaid plans when the Hyde Amendment provides funding for abortions under certain specific circumstances. These four federal appellate courts uniformly held that the intent of Congress in enacting the Hyde Amendment was to ensure that states fund abortions in those narrow instances where federal funds were available under the Hyde Amendments. *See, Roe v. Casey*, 623 F.2d 829 (3rd Cir.1980); *Hodgson v. Board of County Commissioners*, 614 F.2d 601 (8th Cir.1980), *Zbaraz v. Quern*, 596 F.2d 196 (7th Cir.1979), *cert. denied*, 448 U.S. 907, 100 S.Ct. 3048, 65 L.Ed.2d 1136 (1980); *Preterm, Inc. v. Dukakis*, 591 F.2d 121 (1st Cir.1979), cert. denied, 441 U.S. 952, 99 S.Ct. 2181, 60 L.Ed.2d 1057 (1979). All four of these Circuits found that Hyde Amendment was intended by

the Congress to modify Title XIX. An earlier version of the Hyde Amendment passed on October 1, 1980, included a provision that no funds shall be used to perform abortions except where the mother's life is endangered or when the mother became pregnant through rape or incest, when the rape was reported with 72 hours to a law enforcement agency, "*Provided, however*, that the several States are and shall remain free not to fund abortions to the extent that they in their sole discretion deem appropriate." Pub.L. 96-369, § 101(c), 94 Stat. 1351, 1352-53 (1980) (emphasis in original). This language was deleted in versions of the amendment passed in later years, including the 1994 amendment. While not deciding this specific issue, the United States Supreme Court has held that withdrawal of federal funds relieves states of any obligation to provide abortions not federally funded. *Harris v. McRae*, 448 U.S. at 310-311, 100 S.Ct. at 2684-2685.

A federal district judge in Michigan has recently ruled that because Michigan law, which provides for Medicaid abortion funding only in situations where the mother's life is endangered, conflicted with Title XIX, as modified by the 1994 Hyde Amendment, and that under the Supremacy Clause, the Michigan statute cannot stand.[1] The court ruled that Michigan was prohibited from enforcing its law while accepting federal funds pursuant to Title XIX. *Planned Parenthood Affiliates of Michigan v. John Engler*, 860 F.Supp. 406 (W.D.Mich.1994). The Michigan court found persuasive the reasoning of the four appellate courts considering the same issue.

Similarly, a federal district judge in Arkansas and a Montana state court judge have decided that statutes in their respective states which limit Medicaid abortion funding only to

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[1] The Michigan statute is, for all practical purposes, identical to the Louisiana statute at issue here.

those instances to save the mother's life, and which make no provision allowing funding for abortions in cases where the pregnancy results from rape or incest, conflicts with applicable federal law and thus violates the Supremacy Clause of the United States Constitution. *Little Rock Family Planning Services, P.A. v. Thomas Dalton*, 860 F.Supp. 609 (E.D.Ark. Little Rock Div., 1994); *Jeanette R. v. State of Montana*, Cause No. BDV-94-811 (1st J.D.Ct.Montana) (June 1, 1994).

This Court, faced with the identical question respecting enforcement of Louisiana's law, has examined exhaustively the memoranda of the parties and the cases cited therein. Also carefully studied were the exhaustive opinions issued by the federal courts in Michigan and Arkansas and the state court in Montana, all of which are attached to this opinion as appendices. The Court is mindful of the fact that when this action was filed, the Louisiana Legislature was still in session and considered, and rejected, an amendment to LSA-R.S. 40:1299.34.5, to be triggered by court action, which would have extended Medicaid abortion funding only to those women whose lives are endangered by their pregnancies or who became pregnant through rape or incest.

Plaintiffs seek both a preliminary and a permanent injunction, arguing that they have established: (1) a substantial likelihood of success on the merits; (2) a substantial threat of irreparable injury; (3) that the threatened injury to them outweighs any damage an injunction might cause defendants; and (4) that the injunction will not undermine the public interest. *Landmark Land Co., Inc. v. OTS*, 990 F.2d 807, 810 (5th Cir.1993); *Lakedreams v. Taylor*, 932 F.2d 1103, 1107 (5th Cir.1991). Because the trial on the merits was consolidated with hearing of the preliminary injunction, the request for preliminary injunction is moot. The Court does note that the plaintiffs did call three witnesses to establish the requirement of a substantial

threat of irreparable injury. [2] Upon request, and with the consent of all parties, the Court is now deciding the merits of this dispute, which is a question of law.

The scope of the permanent injunctive relief and declaratory judgment the plaintiffs seek is an injunction prohibiting the defendants, and their successors, from enforcing LSA-40:1299.34.5, a declaration that the State of Louisiana must return all federal Medicaid funding if it chooses not to comply with the mandate of the 1994 Hyde Amendment, and ordering them to pay for plaintiff Zora H.'s abortion.

The State of Louisiana advances a two-prong argument, first that neither Hope Medical Group for Women nor Dr. Okpalobi have standing to raise these issues because they have not alleged that they have suffered an "injury in fact," i.e., that they have performed abortion procedures on women who have become pregnant through rape or incest and have been denied Medicaid payment for these procedures. Dr. Okpalobi did file a Request for Admissions under Rule 36 of the Federal Rules of Civil Procedure of three separate statement, which the State admitted at the hearing and in writing in the record, and a stipulation. The parties stipulated that Dr. Okpalobi is a duly-licensed physician practicing in this district who treats Medicaid-eligible patients and has been issued a Louisiana

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[2] The three witnesses were experts who testified on abortion statistics in America and in the state of Louisiana, on the incidence of rape and the effect of rape, and pregnancy resulting from rape, on women, and on the medical effects on patients who are delayed in their obtaining their abortions because of the denial of Medicaid funding. The testimony did establish that if a woman becomes pregnant as a result of rape or incest and she is sufficiently impecunious that she meets Medicaid eligibility standards, the delay caused by a search for funds to obtain an abortion, particularly if the delay causes her pregnancy to advance to the second trimester, would be detrimental to her health.

Medicaid identification number. The State admitted that Louisiana participates in the Federal Medicaid Program, that the Medicaid Director has been notified of the 1994 Hyde Amendment, and that Louisiana law prohibits the State in administering its Medicaid program from permitting public funds to be used to pay for abortions in cases where the patient became pregnant through rape or incest, unless the abortion is medically necessary to save the life of the patient.

The Court finds that Dr. Okpalobi, who already is a Medicaid Provider, and Hope Medical Group for Women, who provides family planning, abortion and counseling services for Medicaid-eligible women who live throughout the state of Louisiana, have standing to bring this action in that they have suffered sufficient "injury in fact." As noted in *Valley Forge v. Americans United for Separation of Church and State*, 454 U.S. 464, 472, 102 S.Ct. 752, 758, 70 L.Ed.2d 700 (1982), the plaintiff must demonstrate some "actual or threatened injury" in order to seek to have the statute invalidated. The State has admitted that its Medicaid program is prohibited from reimbursing either patients or medical care providers for abortions in circumstances when the patient became pregnant as a result of rape or incest. Thus, the economic injury is "threatened" and it would be futile and serve no useful purpose to require the plaintiffs to submit a bill to the state of Louisiana and have it denied. The State has, in effect, admitted that no reimbursement would be forthcoming if they submitted claims. Physicians have standing to assert the rights of their patients when they will benefit financially from federal Medicaid reimbursement for the services they provide. *See, Singleton v. Wulff*, 428 U.S. 106, 96 S.Ct. 2868, 49 L.Ed.2d 826 (1976), on remand, 538 F.2d 811 (8th Cir.1976).

The second argument propounded by the State is that the 1994 Hyde Amendment does not conflict with LSA-R.S.

40:1299.34.5 in that it *permits*, but does not *require* states to provide Medicaid funding for abortions when the procedure is necessary to save the life of the mother or when the pregnancy is the result of an act of rape or incest. Unfortunately for the State, this same argument has been advanced, and rejected, in the four federal appellate courts which have considered it, as well as in recent decisions in Michigan, Arkansas and Montana. The precedents established by the jurisprudence on this question are clear, direct, and persuasive. [3]

As to the request for a permanent injunction regarding enforcement of the law, based upon the precedents established by four appellate circuits, and the recent district court decisions, for the reasons cited, the Court finds that the plaintiffs are entitled to a permanent injunction enjoining defendants from enforcing LSA-R.S. 40:1299.34.5, which prohibits state Medicaid funding for abortions to terminate pregnancies when the mother became pregnant through acts of rape or incest, while accepting federal funds pursuant to Title XIX. As to the request for an order requiring the state to pay for Zora H.'s abortion, the Court finds that states are not **required** to accept Medicaid funds, but if they do, they must provide medically necessary services. Since the Louisiana legislature has obviously chosen not to accept federal funds under Title XIX, because they have refused to amend the law to provide funding in these very narrow circumstances, the Court cannot order the state to pay for Zora H.'s abortion. As to the request for declaratory judgment, the Court finds that the State of Louisiana cannot accept federal Medicaid funding, while refusing to comply with the 1994 Hyde Amendment and provide Medicaid reimbursement to eligible women who have abortions terminating pregnancies resulting from rape or incest. The

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[3] The State of Louisiana has not provided the Court with a case decided in its favor on the question posed by this litigation.

United States is not a party to this action and has requested no relief.

The Court regrets any adverse effects this ruling may have on the numerous Medicaid eligible persons seeking medically necessary services for all types of medical conditions. The Louisiana state legislature was afforded an opportunity to correct this problem to save federal funding for the many needy adults and children whose illnesses or injuries could be treated or cured through services funded through the Medicaid program. Nor does the Court express any personal opinion whatsoever on the moral or religious issues surrounding abortions. Indeed, such an opinion would be inconsistent with this Court's sworn duty as a judicial officer. Congress has mandated that Medicaid programs in those states which choose to accept federal funding provide abortion funding in three extremely limited circumstances, to protect the life of the mother or in cases where the mother became pregnant through rape or incest. Any state which accepts federal funds for Medicaid programs must also follow federal requirements and regulations or lose this funding.

Accordingly,

IT IS ORDERED that the motion of plaintiffs for a preliminary injunction be and is hereby GRANTED IN PART and DENIED IN PART as follows:

1) That the defendants be and are hereby enjoined from enforcing LSA-R.S. 40:1299.34.5, insofar as it prohibits state funding for abortions to terminate pregnancies resulting from acts of rape or incest, as required by Title XIX, modified by the Hyde Amendment, while at the same time accepting federal funds pursuant to Title XIX;

2) That Zora H. be denied a preliminary injunction ordering the state to reimburse her the cost of her abortion.

JUDGMENT

Considering the record, the Reasons for Judgment entered this date, and the law, for the reasons assigned,

IT IS ORDERED, ADJUDGED, AND DECREED that there be judgment herein as follows:

1) That the defendants EDWIN EDWARDS, Governor of the State of Louisiana, RICHARD IEYOUB, Attorney General of the State of Louisiana, and ROSE FORREST, Secretary of the Louisiana Department of Health and Hospitals, in their official capacities and their successors, be and are hereby enjoined from enforcing LSA-R.S. 40:1299.34.5, insofar as it prohibits state funding for abortions to terminate pregnancies resulting from acts of rape or incest, as required by Title XIX, modified by the Hyde Amendment, while at the same time accepting federal funds pursuant to Title XIX;

2) That Zora H. be denied a preliminary injunction ordering the state to reimburse her the cost of her abortion.

APPENDIX C

[Filed August 1, 1994]

UNITED STATES DISTRICT COURT EASTERN DISTRICT OF LOUISIANA

HOPE MEDICAL GROUP FOR WOMEN, on behalf of itself and the Medicaid-eligible women of the State of Louisiana to whom it provides health care; IFEANYI CHARLES OKPALOBI, M.D., on behalf of himself and his Medicaid-eligible patients seeking abortions; and ZORA H. (a pseudonym), on behalf of herself,

versus

EDWIN EDWARDS, Governor of the State of Louisiana, RICHARD IEYOUB, Attorney General of the State of Louisiana; ROSE FORREST, Secretary of the Louisiana Department of Health and Hospitals; in their official capacities and their successors

NO. 94-1129

SECTION: E/2

ORDER

A hearing was held on the motion of defendants for stay of the judgment pursuant to F.R.C.P. 62 and for injunction pending appeal. The parties were notified by telephone of the hearing, held on an expedited basis. Present were:

WILLIAM E. RITTENBERG, for plaintiff Hope Medical
SIDNEY M. BACH, for plaintiff Dr. Okpalobi
BARBARBA RUTLEDGE, of Attorney General's Office, for defendants

Considering the arguments presented by counsel, the memoranda filed by the parties, and the law, the Court attempting to balance the interests of the plaintiffs with the

needs of other Medicaid-eligible persons who *might* be adversely effected by the denial of a stay,

IT IS ORDERED that the judgment entered by the this Court on July 28, 1994, be and is hereby STAYED until August 19, 1994 at 5:00 p.m., wherein this stay shall expire.

APPENDIX D

UNITED STATES DISTRICT COURT EASTERN DISTRICT OF LOUISIANA

HOPE MEDICAL GROUP FOR WOMEN, on behalf of itself and the Medicaid-eligible women of the State of Louisiana to whom it provides health care; IFEANYI CHARLES OKPALOBI, M.D., on behalf of himself and his Medicaid-eligible patients seeking abortions; and ZORA H. (a pseudonym),

Plaintiffs

vs.

EDWIN EDWARDS, Governor of the State of Louisiana; RICHARD IEYOUB, Attorney General of the State of Louisiana; ROSE FORREST, Secretary of the Louisiana Department of Health and Hospitals; in their official capacities and their successors,

Defendants.

Civil Action
No. 94-1129
Section "E" (2)

ORDER

Considering the foregoing Motion;

IT IS ORDERED that the defendants' Motion for Stay Pursuant to F.R.C.P. 62 and for Injunction Pending Appeal is hereby granted, staying the effect of the Judgment of this court entered on July 28, 1994.

New Orleans, Louisiana this _____ day of _____, 1994

_____
DISTRICT JUDGE

/s/ 8-9-94 DENIED
/s/ MARCEL LIVAUDAIS

APPENDIX E

Edwin EDWARDS, Governor of Louisiana, et al.,

v.

HOPE MEDICAL GROUP FOR WOMEN, et al.

No. A-124.

Aug. 17, 1994.

Justice SCALIA, Circuit Justice.

Applicants, officers of the State of Louisiana, ask that I stay an order entered by the United States District Court for the Eastern District of Louisiana which enjoins them from enforcing La.Rev.Stat.Ann. s 40:1299.34.5 (West 1994) while at the same time accepting federal Medicaid funds pursuant to Title XIX of the Social Security Act, 42 U.S.C. s 1396 et seq. The District Court stayed its judgment until 5:00 p.m. on August 19, 1994. Yesterday, the Court of Appeals for the Fifth Circuit unanimously denied the applicants' motion for stay pending appeal.

Section 40:1299.34.5 provides in relevant part:

> [N]o public funds . . . shall be used in any way for, to assist in, or to provide facilities for an abortion, except when the abortion is medically necessary to prevent the death of the mother.

The District Court concluded that this statute was inconsistent with what it determined to be the requirement of Title XIX, as modified by the 1994 version of the Hyde Amendment, Pub.L. No. 103-112 § 509, 107 Stat. 1082, 1113 (1993), that States participating in the Medicaid program fund medically necessary abortions upon fetuses conceived by acts of rape or incest. Accordingly, it ordered applicants either to cease enforcing section 40:1299.34.5 or to withdraw from participation in the Medicaid program. *Hope Medical Group for Women v. Edwards*, No. 94-1129, 1994 WL 419895 (E.D.La. July 28, 1994).

The practice of the Justices has consistently been to grant a stay only when three conditions obtain. There must be a reasonable probability that certiorari will be granted, a significant possibility that the judgment below will be reversed, and a likelihood of irreparable harm (assuming the applicant's position is correct) if the judgment below is not stayed. *Barnes v. E-Systems, Inc. Group Hosp. Medical & Surgical Ins. Plan*, ——U.S. ——, ——, 112 S.Ct. 1, 2, 115 L.Ed.2d 1087 (1991) (Scalia, J., in chambers). Moreover, when a District Court judgment is reviewable by a Court of Appeals that has denied a motion for a stay, the applicant seeking an overriding stay from this Court bears "an especially heavy burden," *Packwood v. Senate Select Comm. on Ethics*, ——U.S. ——, ——, 114 S.Ct. 1036, 1037, 127 L.Ed.2d 530 (1994) (Rehnquist, C.J., in chambers).

Under this standard, I have no authority to stay the judgment here. The only issue potentially worthy of certiorari is the premise underlying the District Court's decision: that Title XIX requires States participating in the Medicaid program to fund abortions (at least "medically necessary" ones) unless federal funding for those procedures is proscribed by the Hyde Amendment. The Courts of Appeals to address this question have uniformly supported that premise. See Roe v. Casey, 623 F.2d 829, 831, 834 (CA3 1980); Hodgson v. Board of County Comm'rs, 614 F.2d 601, 611 (CA8 1980); Zbaraz v. Quern, 596 F.2d 196, 199 (CA7 1979), cert. denied, 448 U.S. 907, 100 S.Ct. 3048, 65 L.Ed.2d 1136 (1980); Preterm, Inc. v. Dukakis, 591 F.2d 121, 126-27, 134 (CA1), cert. denied, 441 U.S. 952, 99 S.Ct. 2181, 60 L.Ed.2d 1057 (1979). We have already denied certiorari in two of those cases, and it is in my view a certainty that four Justices will not be found to vote for certiorari on the Title XIX question unless and until a conflict in the Circuits appears.

Accordingly, the application for a stay of the judgment of the District Court for the Eastern District of Louisiana is denied.

APPENDIX F

UNITED STATES DISTRICT COURT EASTERN DISTRICT OF LOUISIANA

HOPE MEDICAL GROUP FOR WOMEN, on behalf of itself and the Medicaid-eligible women of the State of Louisiana to whom it provides health care; IFEANYI CHARLES OKPALOBI, M.D., on behalf of himself and his Medicaid-eligible patients seeking abortions; and ZORA H. (a pseudonym),

Plaintiffs,

vs.

EDWIN EDWARDS, Governor of the State of Louisiana; RICHARD IEYOUB, Attorney General of the State of Louisiana; ROSE FORREST, Secretary of the Louisiana Department of Health and Hospitals; in their official capacities and their successors,

Defendants.

Civil Action
No. 94-1129
Section "E" (2)

ORDER

Considering the foregoing Motion for Extension of Stay filed by the defendants in this matter,

IT IS ORDERED that the judgment entered by this Court on July 28, 1994, be and is hereby STAYED until August 25, 1994 at 5:00 p.m., wherein this stay shall expire.

New Orleans, Louisiana this 19 day of August, 1994 at 10:05 a.m.

/s/ MARCEL LIVAUDAIS, JR.

MARCEL LIVAUDAIS, JR.
United States District Judge

APPENDIX G

[Filed October 17, 1995]

In The United States Court of Appeals for the Fifth Circuit

No. 94-30445

HOPE MEDICAL GROUP FOR WOMEN, on behalf of itself and the Medicaid eligible women of the State of Louisiana to whom it provides health care and IFEANYI CHARLES OKPALOBI, MD., on behalf of himself and his Medicaid-elibigle patients seeking abortions, ET AL.,

Plaintiffs-Appellees,

versus

EDWIN EDWARDS, Governor of the State of Louisiana, ET AL.,

Defendants-Appellants.

Appeal from the United States District Court for the Eastern District of Louisiana

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ON PETITION FOR HEARING

(October 17, 1995)

Before WISDOM, GARWOOD and DAVIS, Circuit Judges.

PER CURIAM:

IT IS ORDERED that the petition for rehearing filed in the above case is denied.

ENTERED FOR THE COURT

/s/ W. EUGENE DAVIS

United States Circuit Judge

APPENDIX H

LOUISIANA PROVISIONS

1. Louisiana Revised Statutes Title 40, Section 1299.35.1 (La. R.S. 40:1299.35.1)

§ 1299.35.1. Definitions

As used in R.S. 40:1299.35.0 through 40:1299.35.18, the following words have the following meanings:

(1) "Abortion" means the deliberate termination of a human pregnancy after fertilization of a female ovum, by any person, including the pregnant woman herself, with an intention other than to produce a live birth or to remove a dead unborn child caused by a spontaneous abortion.

2. La. R.S. 40:1299.34.5 as it existed at the commencement of this lawsuit. (Before the amended by Act No. 1 of the Fourth Extraordinary Session of the Louisiana Legislature, August 23, 1994.)

§ 1299.34.5. Use of public funds

Notwithstanding any other provision of law to the contrary, no public funds, made available to any institution, board, commission, department, agency, official, or employee of the state of Louisiana, or of any local political subdivision thereof, whether such funds are made available by the government of the United States, the state of Louisiana, or of a local governmental subdivision, or from any other public source shall be used in any way for, to assist in, or to provide facilities for an abortion, except when the abortion is medically necessary to prevent the death of the mother.

3. La. R.S. 40:1299.34.5 as it currently reads after being amended by Act No. 1 of the Fourth Extraordinary Session of the Louisiana Legislature August 23, 1994, which

act was enacted during the pendency of this case, after the United States District Court's judgment, and during the extended temporary stay ordered by the United States District Court, but before the consideration of appeal and the judgment of the United States Court of Appeal for the Fifth Circuit sought to be reviewed herein.

§ 1299.34.5 Use of public funds

A. Notwithstanding any other provision of law to the contrary, no public funds, made available to any institution, board, commission, department, agency, official, or employee of the state of Louisiana, or of any local political subdivision thereof, whether such funds are made available by the government of the United States, the state of Louisiana, or of a local governmental subdivision, or from any other public source shall be used in any way for, to assist in, or to provide facilities for an abortion, except when the abortion is medically necessary to prevent the death of the mother.

B. Notwithstanding any other provision of law to the contrary, no public funds made available to any institution, board, commission, department, agency, official, or employee of the state of Louisiana, or of any local political subdivision thereof, whether such funds are made available by the government of the United States, the state of Louisiana, or a local governmental subdivision, or from any other public source, shall be used in any way for, to assist in, or to provide facilities for an abortion, except for any of the following:

(1) Whenever the abortion is necessary to save the life of the mother.

(2) Whenever the abortion is being sought to terminate a pregnancy resulting from an alleged act of rape and all of the requirements of R.S. 40:1299.35.7(A) are met.

(3) Whenever the abortion is being sought to terminate a pregnancy resulting from an alleged act of incest and all of the requirements of R.S. 40:1299.35.7(B) are met.

C. The secretary of the Department of Health and Hospitals shall promulgate rules to insure that no funding of any abortion shall be made based upon a claim of rape or incest until the applicable requirements of R.S. 40:1299.35.7 have been complied with and written verification has been obtained from the physician performing the abortion and from the law enforcement official to whom the report is made, if applicable.

D. Subsection A of this Section shall be superseded and Subsections B and C and R.S. 40:1299.35.7 shall become effective only when the circumstances in Subparagraph (1)(a) or in Subparagraph (2)(a) occur:

(1)(a) A decision or order of a court of competent jurisdiction is rendered declaring the provisions of Subsection A unconstitutional, inconsistent with federal law, or otherwise unenforceable based on inconsistency with the Hyde Amendment, or enjoins the state or any of its officials from enforcing Subsection A while at the same time accepting federal funds pursuant to Title XIX, as modified by the Hyde Amendment, and then only if, as, and when a stay pending all appeals of the decision or order is denied, or, if a stay is granted, such stay expires or is no longer effective.

(b) If such a decision or order is rendered, the state Department of Justice, on behalf of the state, shall vigorously and expeditiously pursue judicial remedies seeking to obtain a stay pending all appeals of the decision or order and its reversal

(2)(a) An order or decision of a court of competent jurisdiction is rendered affirming a finding of the adminis-

trator of the Health Care Financing Administration of the United States Department of Health and Human Services that Subsection A fails to substantially comply with the Hyde Amendment or denying a stay of the finding of the administrator and then only if, as, and when the state receives formal notification from the administrator that Medicaid funds, including but not limited to the federal percentage of Medicaid assistance payments pursuant to 42 U.S.C. 1396 et seq. allocated to the state from the United States government, will be withheld or terminated on a specified date.

(b) If the administrator finds that the state is in noncompliance with the Hyde Amendment as it relates to funding certain abortions, the governor, the state Department of Justice, and the state Department of Health and Hospitals, on behalf of the state, shall vigorously and expeditiously pursue administrative and judicial remedies to obtain a stay of the finding and its reversal.

(c) If such a decision or order is rendered by a court, the state Department of Justice, on behalf of the state, shall vigorously and expeditiously pursue judicial remedies seeking to obtain a stay of the decision or order and to seek its reversal.

E. If Subsections B and C and R.S. 40:1299.35.7 become effective and subsequently the federal requirement for acceptance of Medicaid funds, that public funds be made available for abortions resulting from pregnancy due to rape or incest, is no longer applicable to the state of Louisiana, then on the same day, the provisions of Subsections B and C and R.S. 40:1299.35.7 shall be superseded and the provisions of Subsection A shall be effective to the fullest extent allowed by law.

APPENDIX I

FEDERAL PROVISIONS

1. 42 U.S.C. § 1396a

§ 1396a. State plans for medical assistance

(a) Contents. A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1396b of this title are authorized by this subchapter; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and includ-

ing provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, and (C) that each State or local officer or employee who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer or employee, and each partner of such an officer or employee shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of Title 18;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program estab-

lished under subchapter XVI of this chapter,

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning

(8) provide that all individuals wishing to make application for medical assistance under

(9) provide—(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1395x(e)(9) of this title or paragraphs (13) and (14) of section 1395x(s) of this title, or, in the case of a laboratory which is in a rural health clinic, of section 1395x(aa)(2)(G) of this title;

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1)

through (5), (17) and (21) of section 1396d(a) of this title, to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including individuals eligible under this subchapter by reason of section 602(a)(37), 606(h), or 673(b) of this title, or considered by the State to be receiving such aid as authorized under section 682(e)(6) of this title),

(II) with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter or who are qualified severely impaired individuals (as defined in section 1396d(q) of this title),

(III) who are qualified pregnant women or children as defined in section 1396d(n) of this title,

(IV) who are described in subparagraph (A) or (B) of subsection (l)(1) of this section and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(2)(A) of this section for such a family;

(V) who are qualified family members as defined in section 1396d(m)(1) of this title;

(VI) who are described in subparagraph (C) of subsection (l)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(B) of this section for such a family, or

(VII) who are described in subparagraph (D) of

subsection (l)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(C) of this section for such a family;

(ii) at the option of the State, to any group or groups of individuals described in section 6d(a) of this title (or, in the case of individuals described in section 6d(a)(i) of this title, to any reasonable categories of such individuals) who are not individuals described in clause (I) of this paragraph but—

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under subchapter XVI of this chapter, or a State supplementary payment;

(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility

by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1396b(f)(4)(C) of this title,

(VI) who would be eligible under the State plan under this subchapter if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in subsection (c), (d), or (e) of section 1396n of this title they would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under subsection (c), (d), or (e) of section 1396n of this title,

(VII) who would be eligible under the State plan under this subchapter if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1396d(o) of this title;

(VIII) who is a child described in section 1396d(a)(i) of this title—

(aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of subchapter IV of this chapter) between the State and an adoptive parent or parents,

(bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assistance because such child has special needs for medical or rehabilitative care, and

(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of subchapter IV of this chapter were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of subchapter IV of this chapter;

(IX) who are described in subsection (l)(1) of this section and are not described in clause (i)(IV), clause (i)(VI), or clause (i)(VII);

(X) who are described in subsection (m)(1) of this section;

(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under subchapter XVI of this chapter), which are available to all individuals in the State (but which may be based on different

income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Commissioner of Social Security under section 1382e or 1383c of this title; or

(XII) who are described in subsection (z)(1) of this section (relating to certain TB-infected individuals);

(B) that the medical assistance made available to any individual described in subparagraph (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1396d(a) of this title who are not described in subparagraph (A) or (E), then—

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individ-

uals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

(ii) the plan must make available medical assistance—

(I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and

(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and

(iv) if such medical assistance includes services in institutions for mental diseases or in an intermediate care facility for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title or the care and services listed in any 7 of the paragraphs numbered (1) through (24) of such section;

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to nursing facility services; and

(E)(i) for making medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title;

(ii) for making medical assistance available for payment of medicare cost- sharing described in section 1396d(p)(3)(A)(i) of this title for qualified disabled and working individuals described in section 1396d(s) of this title; and

(iii) for making medical assistance available for medicare cost sharing described in section 1396d(p)(3)(A)(ii) of this title subject to section 1396d(p)(4) of this title, for individuals who would be qualified medicare beneficiaries described in section 1396d(p)(1) of this title but for the fact that their income exceeds the income level established by the State under section 1396d(p)(2) of this title but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the official poverty line (referred to in such section) for a family of the size involved; and

(F) at the option of a State, for making medical assistance available for COBRA premiums (as defined in subsection (u)(2) of this section) for qualified COBRA continuation beneficiaries described in subsection (u)(1) of this section; except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1396d(a) of this title to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplemen-

tary medical insurance benefits under part B of subchapter XVIII of this chapter to individuals eligible therefor (either pursuant to an agreement entered into under section 1395v of this title or by reason of the payment of premiums under such subchapter by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of subchapter XVIII of this chapter for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A), (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1396o(a)(2) or (b)(2) of this title shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other

condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan, (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1396d(o) of this title to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under subchapter XVIII of this chapter, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals, (VII) the medical assistance made available to an individual described in subsection (l)(1)(A) of this section who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate pregnancy, (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1396d(p)(1) of this title who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost-sharing (described in section 1396d(p)(3) of this title), subject to the provisions of subsection (n) of this section

and section 1396o(b) of this title, (IX) the making available of respiratory care services in accordance with subsection (e)(9) of this section shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A) of this section, provided such services are made available (in the same amount, duration, and scope) to all individuals described in such subsection, (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1396r-4(a)(1)(A) of this title, as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals, (XI) the making available of medical assistance to cover the costs of premiums, deductibles, coinsurance, and other cost-sharing obligations for certain individuals for private health coverage as described in section 1396e of this title shall not, by reason of paragraph (10), require the making available of any such benefits or the making available of services of the same amount, duration, and scope of such private coverage to any other individuals, (XII) the medical assistance made available to an individual described in subsection (u)(1) of this section who is eligible for medical assistance only because of subparagraph (F) shall be limited to medical assistance for COBRA continuation premiums (as defined in subsection (u)(2) of this

section), and (XIII) the medical assistance made available to an individual described in subsection (z)(1) of this section who is eligible for medical assistance only because of subparagraph (A)(ii)(XII) shall be limited to medical assistance for TB-related services (described in subsection (z)(2) of this section);

(11) (A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan, (B) provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments under (or through an allotment under) subchapter V of this chapter, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such subchapter or allotment and which are included in the State plan approved under this section (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to the individual under section 1396b of this title, and (iii) providing for coordination of information and education on pediatric vaccinations and delivery of immunization services, and (C) provide for coordination of the operations under this subchapter, including the provision of information and education on pediatric vaccinations and the delivery of immunization services, with the State's operations under the special supplemental nutrition program for women, infants, and children under section 1786 of this title;

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(13) provide—

(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State which, in the case of nursing facilities, take into account the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter) of complying with subsections (b) (other than paragraph (3)(F) thereof), (c), and (d) of section 1396r of this title and provide (in the case of a nursing facility with a waiver under section 1396r(b)(4)(C)(ii) of this title) for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care, and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1395x(v)(1)(G) of this title), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1395x(v)(1)(G) of this title) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be

incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, nursing facility, and intermediate care facility for the mentally retarded and periodic audits by the State of such reports;

(B) that the State shall provide assurances satisfactory to the Secretary that the payment methodology utilized by the State for payments to hospitals can reasonably be expected not to increase such payments, solely as a result of a change of ownership, in excess of the increase which would result from the application of section 1395x(v)(1)(O) of this title;

(C) that the State shall provide assurances satisfactory to the Secretary that the valuation of capital assets, for purposes of determining payment rates for nursing facilities and for intermediate care facilities for the mentally retarded, will not be increased (as measured from the date of acquisition by the seller to the date of the change of ownership), solely as a result of a change of ownership, by more than the lesser of—

(i) one-half of the percentage increase (as measured over the same period of time, or, if necessary, as extrapolated retrospectively by the Secretary) in the Dodge Construction Systems Costs for Nursing Homes, applied in the aggregate with respect to those facilities which have undergone a change of ownership during the fiscal year, or

(ii) one-half of the percentage increase (as measured over the same period of time) in the Consumer Price Index for All Urban Consumers (United States city average);

(D) for payment for hospice care in amounts no lower than the amounts, using the same methodology, used under part A of subchapter XVIII of this chapter and for payment of amounts under section 1396d(o)(3) of this title; except that in the case of hospice care which is furnished to an individual who is a resident of a nursing facility or intermediate care facility for the mentally retarded, and who would be eligible under the plan for nursing facility services or services in an intermediate care facility for the mentally retarded if he had not elected to receive hospice care, there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual;

(E) for payment for services described in clause (B) or (C) of section 1396d(a)(2) of this title under the plan of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary prescribes in regulations under section 1395l(a)(3) of this title, or, in the case of services to which those regulations do not apply, on the same methodology used under section 1395l(a)(3) of this title; and

(F) for payment for home and community care (as defined in section 1396t(a) of this title and provided under such section) through rates which are reasonable and adequate to meet the costs of providing care, efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards;

(14) provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1396o of this title;

(15) Repealed. Pub.L. 100-360, Title III, s 301(e)(2)(C), as added Pub.L. 100-485, Title VI, § 608(d)(14)(I)(iii), Oct. 13, 1988, 102 Stat. 2416

(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

(17) except as provided in subsections (l)(3), (m)(3), and (m)(4) of this section, include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved un-

der subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums, payments made to the State under section 1396b(f)(2)(B) of this title, or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State law;

(18) comply with the provisions of section 1396p of this title with respect to liens, adjustments and recoveries of medical assistance correctly paid, transfers of assets, and treatment of certain trusts;

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodic determination of his need for continued treatment in the institution; and

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 303(a)(4)(A)(i) and (ii) or section 1383(a)(4)(A)(i) and (ii) of this title which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out;

(21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases;

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality;

(23) except as provided in subsection (g) of this section and in section 1396n of this title and except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to

provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1396n(b)(1) of this title), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1396d(a)(4)(C) of this title;

(24) effective July 1, 1969, provide for consultative services by health agencies and other appropriate agencies of the State to hospitals, nursing facilities, home health agencies, clinics, laboratories, and such other institutions as the Secretary may specify in order to assist them (A) to qualify for payments under this chapter, (B) to establish and maintain such fiscal records as may be necessary for the proper and efficient administration of this chapter, and (C) to provide information needed to determine payments due under this chapter on account of care and services furnished to individuals;

(25) provide—

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. s 1167(1)]), service benefit plans, and health maintenance organizations) to pay for care and services available under the plan, including—

(i) the collection of sufficient information (including the use of information collected by the Medicare and Medicaid Coverage Data Bank under section 1320b-14 of this title and any additional information as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with

such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall—

(I) be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval system under section 1396b(r) of this title, and

(II) be subject to the provisions of section 1396b(r)(4) of this title relating to reductions in Federal payments for failure to meet conditions of approval, but shall not be subject to any other financial penalty as a result of any other monitoring, quality control, or auditing requirements;

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the

plan (disregarding section 1396o of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1396o of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396o of this title), exceeds the total of the amount of the liabilities of third parties for that service;

(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;

(E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1396d(a)(4)(B) of this title) covered under the State plan, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of subchapter IV of this chapter, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability

is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(G) that the State plan shall meet the requirements of section 1396e of this title (relating to enrollment of individuals under group health plans in certain cases);

(H) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1167(1)], a service benefit plan, and a health maintenance organization), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this title for such State, or any other State; and

(I) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services;

(26) if the State plan includes medical assistance for inpatient mental hospital services, provide—

(A) with respect to each patient receiving such services,

for a regular program of medical review (including medical evaluation) of his need for such services, and for a written plan of care;

(B) for periodic inspections to be made in all mental institutions within the State by one or more medical review teams (composed of physicians and other appropriate health and social service personnel) of the care being provided to each person receiving medical assistance, including (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the institution, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

(C) for full reports to the State agency by each medical review team of the findings of each inspection under subparagraph (B), together with any recommendations;

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request;

(28) provide—

(A) that any nursing facility receiving payments under such plan must satisfy all the requirements of subsections (b) through (d) of section 1396r of this title as they apply to such facilities;

(B) for including in "nursing facility services" at least the items and services specified (or deemed to be specified) by the Secretary under section 1396r(f)(7) of this title and making available upon request a description of the items and services so included;

(C) for procedures to make available to the public the data and methodology used in establishing payment rates for nursing facilities under this subchapter; and

(D) for compliance (by the date specified in the respective sections) with the requirements of—

(i) section 1396r(e) of this title;

(ii) section 1396r(g) of this title (relating to responsibility for survey and certification of nursing facilities); and

(iii) sections 1396r(h)(2)(B) and 1396r(h)(2)(D) of this title (relating to establishment and application of remedies);

(29) include a State program which meets the requirements set forth in section 1396g of this title, for the licensing of administrators of nursing homes;

(30) (A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area;

(B) provide, under the program described in subparagraph (A), that—

(i) each admission to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases is reviewed or screened in accordance with criteria established by medical and other professional personnel who are not themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and are not, except in the case of a hospital, employed by the institution providing the care involved, and

(ii) the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the sample of admissions to be subject to review and evaluation by such personnel, and any such sample may be of any size up to 100 percent of all admissions and must be of sufficient size to serve the purpose of (I) identifying the patterns of care being provided and the changes occurring over time in such patterns so that the need for modification may be ascertained, and (II) subjecting admissions to early or more extensive review where information indicates that such consideration is warranted to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases; and

(C) use a utilization and quality control peer review organization (under part B of subchapter XI of this chapter), an entity which meets the requirements of section 1320c-1 of this title, as determined by the Secretary, or a

private accreditation body to conduct (on an annual basis) an independent, external review of the quality of services furnished under each contract under section 1396b(m) of this title, with the results of such review made available to the State and, upon request, to the Secretary, the Inspector General in the Department of Health and Human Services, and the Comptroller General;

(31) with respect to services in an intermediate care facility for the mentally retarded (where the State plan includes medical assistance for such services) provide—

(A) with respect to each patient receiving such services, for a written plan of care, prior to admission to or authorization of benefits in such facility, in accordance with regulations of the Secretary, and for a regular program of independent professional review (including medical evaluation) which shall periodically review his need for such services;

(B) with respect to each intermediate care facility for the mentally retarded within the State, for periodic onsite inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social service personnel), including with respect to each such person (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well- being, (ii) the necessity and desirability of his continued placement in the facility, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

(C) for full reports to the State agency by each independent professional review team of the findings of each in-

spection under subparagraph (B), together with any recommendations;

(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that—

(A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service;

(B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the billings

therefor, and is not dependent upon the actual collection of any such payment;

(C) in the case of services furnished (during a period that does not exceed 14 continuous days in the case of an informal reciprocal arrangement or 90 continuous days (or such longer period as the Secretary may provide) in the case of an arrangement involving per diem or other fee-for-time compensation) by, or incident to the services of, one physician to the patients of another physician who submits the claim for such services, payment shall be made to the physician submitting the claim (as if the services were furnished by, or incident to, the physician's services), but only if the claim identifies (in a manner specified by the Secretary) the physician who furnished the services; and

(D) in the case of payment for a childhood vaccine administered before October 1, 1994, to individuals entitled to medical assistance under the State plan, the State plan may make payment directly to the manufacturer of the vaccine under a voluntary replacement program agreed to by the State pursuant to which the manufacturer (i) supplies doses of the vaccine to providers administering the vaccine, (ii) periodically replaces the supply of the vaccine, and (iii) charges the State the manufacturer's price to the Centers for Disease Control and Prevention for the vaccine so administered (which price includes a reasonable amount to cover shipping and the handling of returns);

(33) provide—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional

health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the second sentence of this subsection; and

(B) that, except as provided in section 1396r(g) of this title, the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title, or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this subchapter the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan, except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation;

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

(35) provide that any disclosing entity (as defined in section 1320a-3(a)(2) of this title) receiving payments under such plan complies with the requirements of section 1320a-3 of this title;

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this subchapter, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization;

(37) provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

(38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, the information described in section 1320a-7(b)(9) of this title;

(39) provide that the State agency shall exclude any specified individual or entity from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1320a-7 of this title or section 1320a-7a of this title, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual or entity during such period;

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1320a(a) of this title to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization;

(41) provide that whenever a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary and, in the case of a physician and notwithstanding paragraph (7), the State medical licensing board of such action;

(42) provide that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to

be necessary to insure that proper payments are made under the plan;

(43) provide for—

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1396d(a)(4)(B) of this title, of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1396d(r) of this title and the need for age-appropriate immunizations against vaccine-preventable diseases,

(B) providing or arranging for the provision of such screening services in all cases where they are requested,

(C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services, and

(D) reporting to the Secretary (in a uniform form and manner established by the Secretary, by age group and by basis of eligibility for medical assistance, and by not later than April 1 after the end of each fiscal year, beginning with fiscal year 1990) the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year:

(i) the number of children provided child health screening services,

(ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services),

(iii) the number of children receiving dental services, and

(iv) the State's results in attaining the participation goals set for the State under section 1396d(r) of this title;

(44) in each case for which payment for inpatient hospital services, services in an intermediate care facility for the mentally retarded, or inpatient mental hospital services is made under the State plan—

(A) a physician (or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician) certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and a physician, a physician assistant under the supervision of a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician, recertifies, where such services are furnished over a period of time, in such cases, at least as often as required under section 1396b(g)(6) of this title (or, in the case of services that are services provided in an intermediate care facility for the mentally retarded, every year), and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services, and

(B) such services were furnished under a plan established and periodically reviewed and evaluated by a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician,

or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician;

(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1396k of this title;

(46) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1320b-7 of this title;

(47) at the option of the State, provide for making ambulatory prenatal care available to pregnant women during a presumptive eligibility period in accordance with section 1396r-1 of this title;

(48) provide a method of making cards evidencing eligibility for medical assistance available to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(49) provide that the State will provide information and access to certain informationrespecting sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1396r-2 of this title;

(50) provide, in accordance with subsection (q) of this section, for a monthly personal needs allowance for certain institutionalized individuals and couples;

(51) meet the requirements of section 1396r-5 of this title (relating to protection of community spouses);

(52) meet the requirements of section 1396r-6 of this title (relating to extension of eligibility for medical assistance);

(53) provide—

(A) for notifying in a timely manner all individuals in the State who are determined to be eligible for medical assistance and who are pregnant women, breastfeeding or postpartum women (as defined in section 1786 of this title), or children below the age of 5, of the availability of benefits furnished by the special supplemental nutrition program under such section, and

(B) for referring any such individual to the State agency responsible for administering such program;

(54) in the case of a State plan that provides medical assistance for covered outpatient drugs (as defined in section 1396r-8(k) of this title), comply with the applicable requirements of section 1396r-8 of this title;

(55) provide for receipt and initial processing of applications of individuals for medical assistance under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX) of this section—

(A) at locations which are other than those used for the receipt and processing of applications for aid under part A of subchapter IV of this chapter and which include facilities defined as disproportionate share hospitals under section 1396r-4(a)(1)(A) of this title and Federally-qualified health centers described in section 1396d(l)(2)(B) of this title, and

(B) using applications which are other than those used for applications for aid under such part;

(56) provide, in accordance with subsection (s) of this section, for adjusted payments for certain inpatient hospital services;

(57) provide that each hospital, nursing facility, provider of

home health care or personal care services, hospice program, or health maintenance organization (as defined in section 1396b(m)(1)(A) of this title) receiving funds under the plan shall comply with the requirements of subsection (w) of this section;

(58) provide that the State, acting through a State agency, association, or other private nonprofit entity, develop a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives that would be distributed by providers or organizations under the requirements of subsection (w) of this section;

(59) maintain a list (updated not less often than monthly, and containing each physician's unique identifier provided under the system established under subsection (v) [FN2] of this section) of all physicians who are certified to participate under the State plan;

(60) provide that the State agency shall provide assurances satisfactory to the Secretary that the State has in effect the laws relating to medical child support required under section 1396g of this title;

(61) provide that the State must demonstrate that it operates a medicaid fraud and abuse control unit described in section 1396b(q) of this title that effectively carries out the functions and requirements described in such section, as determined in accordance with standards established by the Secretary, unless the State demonstrates to the satisfaction of the Secretary that the effective operation of such a unit in the State would not be cost- effective because minimal fraud exists in connection with the provision of covered services to eligible individuals under the State plan, and that beneficiaries under the plan will be protected from abuse and neglect in connection with the provision of

medical assistance under the plan without the existence of such a unit; and

(62) provide for a program for the distribution of pediatric vaccines to program-registered providers for the immunization of vaccine-eligible children in accordance with section 1396s of this title.

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this subchapter, the State agency which administered or supervised the administration of the plan of such State approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under subchapter I of this chapter (or subchapter XVI of this chapter, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this subchapter (except for purposes of paragraph (10)). The provisions of paragraphs (9)(A), (31), and (33) and of section 1396b(i)(4) of this title shall not apply to a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid or as-

sistance under a State plan approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter and who for such month was entitled to monthly insurance benefits under subchapter II of this chapter shall for purposes of this subchapter only be deemed to be eligible for financial aid or assistance for any month thereafter if such individual would have been eligible for financial aid or assistance for such month had the increase in monthly insurance benefits under subchapter II of this chapter resulting from enactment of Public Law 92-336 not been applicable to such individual.

The requirement of clause (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement. For purposes of this subchapter, any child who meets the requirements of paragraph (1) or (2) of section 673(b) of this title shall be deemed to be a dependent child as defined in section 606 of this title and shall be deemed to be a recipient of aid to families with dependent children under part A of subchapter IV of this chapter in the State where such child resides. Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only in accordance with section 1396b(v) of this title.

(b)Approval by Secretary

The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan—

(1) an age requirement of more than 65 years; or

(2) any residence requirement which excludes any individual who resides in the State, regardless of whether or not the residence is maintained permanently or at a fixed address; or

(3) any citizenship requirement which excludes any citizen of the United States.

(c) Lower payment levels or applying for benefits as condition of applying for, or receiving, medical assistance.

Notwithstanding subsection (b) of this section, the Secretary shall not approve any State plan for medical assistance if—

(1) the State has in effect, under its plan established under part A of subchapter IV of this chapter, payment levels that are less than the payment levels in effect under such plan on May 1, 1988; or

(2) the State requires individuals described in subsection (l)(1) of this section to apply for benefits under such part as a condition of applying for, or receiving, medical assistance under this subchapter.

(d) Performance of medical or utilization review functions

If a State contracts with an entity which meets the requirements of section 1320c-1 of this title, as determined by the Secretary, for the performance of the quality review functions de-

scribed in subsection (a)(30)(C) of this section, or a utilization and quality control peer review organization having a contract with the Secretary under part B of subchapter XI of this chapter for the performance of medical or utilization review functions (including quality review functions described in subsection (a)(30)(C) of this section) required under this subchapter of a State plan with respect to specific services or providers (or services or providers in a geographic area of the State), such requirements shall be deemed to be met for those services or providers (or services or providers in that area) by delegation to an entity or organization under the contract of the State's authority to conduct such review activities if the contract provides for the performance of activities not inconsistent with part B of subchapter XI of this chapter and provides for such assurances of satisfactory performance by an entity or organization as the Secretary may prescribe.

(e) Continued eligibility of families determined ineligible because of income and resources or hours of work limitations of plan; individuals enrolled with health maintenance organizations; persons deemed recipients of supplemental security income or State supplemental payments; entitlement for certain newborns; postpartum eligibility for pregnant women

(1) (A) Notwithstanding any other provision of this subchapter, effective January 1, 1974, subject to subparagraph (B) each State plan approved under this subchapter must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of subchapter IV of this chapter in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased hours of, or increased income from, employment, shall, while a member of such family is employed, remain eligible for assistance under the plan approved under this subchap-

ter (as though the family was receiving aid under the plan approved under part A of subchapter IV of this chapter) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of subchapter IV of this chapter because of income and resources or hours of work limitations contained in such plan.

(B) Subparagraph (A) shall not apply with respect to families that cease to be eligible for aid under part A of subchapter IV of this chapter during the period beginning on April 1, 1990, and ending on September 30, 1998. During such period, for provisions relating to extension of eligibility for medical assistance for certain families who have received aid pursuant to a State plan approved under part A of subchapter IV of this chapter and have earned income, see section 1396r-6 of this title.

(2) (A) In the case of an individual who is enrolled with a qualified health maintenance organization (as defined in Title XIII of the Public Health Service Act [42 U.S.C.A. § 300e et seq.]) or with an entity described in paragraph (2)(B)(iii), (2)(E), (2)(G), or (6) of section 1396b(m) of this title under a contract described in section 1396b(m)(2)(A) of this title or with an eligible organization with a contract under section 1395mm of this title and who would (but for this paragraph) lose eligibility for benefits under this subchapter before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this subchapter, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but, except for benefits furnished under section 1396d(a)(4)(C) of this title, only with respect to such benefits provided to the individual as an enrollee of such organization or entity.

(B) For purposes of subparagraph (A), the term "minimum enrollment period" means, with respect to an individual's enrollment with an organization or entity under a State plan, a period, established by the State, of not more than six months beginning on the date the individual's enrollment with the organization or entity becomes effective.

(3) At the option of the State, any individual who—

(A) is 18 years of age or younger and qualifies as a disabled individual under section 1382c(a) of this title;

(B) with respect to whom there has been a determination by the State that—

(i) the individual requires a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded,

(ii) it is appropriate to provide such care for the individual outside such an institution, and

(iii) the estimated amount which would be expended for medical assistance for the individual for such care outside an institution is not greater than the estimated amount which would otherwise be expended for medical assistance for the individual within an appropriate institution; and

(C) if the individual were in a medical institution, would be eligible for medical assistance under the State plan under this subchapter, shall be deemed, for purposes of this subchapter only, to be an individual with respect to whom a supplemental security income payment, or State supplemental payment, respectively, is being paid under subchapter XVI of this chapter.

(4) A child born to a woman eligible for and receiving med-

ical assistance under a State plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of one year so long as the child is a member of the woman's household and the woman remains (or would remain if pregnant) eligible for such assistance. During the period in which a child is deemed under the preceding sentence to be eligible for medical assistance, the medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires).

(5) A woman who, while pregnant, is eligible for, has applied for, and has received medical assistance under the State plan, shall continue to be eligible under the plan, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan, through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.

(6) In the case of a pregnant woman described in subsection (a)(10) of this section who, because of a change in income of the family of which she is a member, would not otherwise continue to be described in such subsection, the woman shall be deemed to continue to be an individual described in subsection (a)(10)(A)(i)(IV) of this section and subsection (l)(1)(A) of this section without regard to such change of income through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends. The preceding sentence shall not apply in the case of a woman who has been provided ambulatory pre-

natal care pursuant to section 1396r-1 of this title during a presumptive eligibility period and is then, in accordance with such section, determined to be ineligible for medical assistance under the State plan.

(7) In the case of an infant or child described in subparagraph (B), (C), or (D) of subsection (l)(1) of this section or paragraph (2) of section 1396d(n) of this title—

(A) who is receiving inpatient services for which medical assistance is provided on the date the infant or child attains the maximum age with respect to which coverage is provided under the State plan for such individuals, and

(B) who, but for attaining such age, would remain eligible for medical assistance under such subsection, the infant or child shall continue to be treated as an individual described in such respective provision until the end of the stay for which the inpatient services are furnished.

(8) If an individual is determined to be a qualified medicare beneficiary (as defined in section 1396d(p)(1) of this title), such determination shall apply to services furnished after the end of the month in which the determination first occurs. For purposes of payment to a State under section 1396b(a) of this title, such determination shall be considered to be valid for an individual for a period of 12 months, except that a State may provide for such determinations more frequently, but not more frequently than once every 6 months for an individual.

(9) (A) At the option of the State, the plan may include as medical assistance respiratory care services for any individual who—

(i) is medically dependent on a ventilator for life support at least six hours per day;

(ii) has been so dependent for at least 30 consecutive days (or the maximum number of days authorized under the State plan, whichever is less) as an inpatient;

(iii) but for the availability of respiratory care services, would require respiratory care as an inpatient in a hospital, nursing facility, or intermediate care facility for the mentally retarded and would be eligible to have payment made for such inpatient care under the State plan;

(iv) has adequate social support services to be cared for at home; and

(v) wishes to be cared for at home.

(B) The requirements of subparagraph (A)(ii) may be satisfied by a continuous stay in one or more hospitals, nursing facilities, or intermediate care facilities for the mentally retarded.

(C) For purposes of this paragraph, respiratory care services means services provided on a part-time basis in the home of the individual by a respiratory therapist or other health care professional trained in respiratory therapy (as determined by the State), payment for which is not otherwise included within other items and services furnished to such individual as medical assistance under the plan.

(10) (A) The fact that an individual, child, or pregnant woman may be denied aid under part A of subchapter IV of this chapter pursuant to section 602(a)(43) of this title shall not be construed as denying (or permitting a State to deny) medical assistance under this subchapter to such individual, child, or woman who is eligible for assistance under this subchapter on a basis other than the receipt of aid under such part.

(B) If an individual, child, or pregnant woman is receiving aid under part A of subchapter IV of this chapter and such aid is terminated pursuant to section 602(a)(43) of this title, the State may not discontinue medical assistance under this subchapter for the individual, child, or woman until the State has determined that the individual, child, or woman is not eligible for assistance under this subchapter on a basis other than the receipt of aid under such part.

(11) (A) In the case of an individual who is enrolled with a group health plan under section 1396e of this title and who would (but for this paragraph) lose eligibility for benefits under this subchapter before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this subchapter, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but only with respect to such benefits provided to the individual as an enrollee of such plan.

(B) For purposes of subparagraph (A), the term "minimum enrollment period" means, with respect to an individual's enrollment with a group health plan, a period established by the State, of not more than 6 months beginning on the date the individual's enrollment under the plan becomes effective.

(f) Effective date of State plan as determinative of duty of State to provide medical assistance to aged, blind, or disabled individuals

Notwithstanding any other provision of this subchapter, except as provided in subsection (e) of this section and section 1382h(b)(3) of this title and section 1396r-5 of this title, except with respect to qualified disabled and working individuals

(described in section 1396d(s) of this title), and except with respect to qualified medicare beneficiaries, qualified severely impaired individuals, and individuals described in subsection (m)(1) of this section, no State not eligible to participate in the State plan program established under subchapter XVI of this chapter shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of subchapter XVI of this chapter) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1396b(f) of this title (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law regardless of whether such expenses are reimbursed under another public program of the State or political subdivision thereof) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to paragraph (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive

medical assistance equal in amount, duration, and scope to that provided to individuals eligible under paragraph (10)(A), or (2) an eligible individual or eligible spouse, as defined in subchapter XVI of this chapter, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under paragraph (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to paragraph (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection.

(g) Reduction of aid or assistance to providers of services attempting to collect from beneficiary in violation of third-party provisions

In addition to any other sanction available to a State, a State may provide for a reduction of any payment amount otherwise due with respect to a person who furnishes services under the plan in an amount equal to up to three times the amount of any payment sought to be collected by that person in violation of subsection (a)(25)(C) of this section.

(h) Payments for home and community care

Nothing in this subchapter (including subsections (a)(13) and (a)(30) of this section) shall be construed as authorizing the Secretary to limit the amount of payment that may be made under a plan under this subchapter for home and community care.

(i) Termination of certification for participation of and suspension of State payments to intermediate care facilities for mentally retarded

(1) In addition to any other authority under State law, where a State determines that a intermediate care facility for the mentally retarded which is certified for participation under its plan no longer substantially meets the requirements for such a facility under this subchapter and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, provide that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the requirements for such a facility under this subchapter, to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the State, and its effectiveness shall terminate (A) when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the requirements for such a facility under this subchapter, or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is

made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.

(j) Waiver or modification of subchapter requirements with respect to medical assistance program in American Samoa

Notwithstanding any other requirement of this subchapter, the Secretary may waive or modify any requirement of this subchapter with respect to the medical assistance program in American Samoa and the Northern Mariana Islands, other than a waiver of the Federal medical assistance percentage, the limitation in section 1308(c) of this title, or the requirement that payment may be made for medical assistance only with respect to amounts expended by American Samoa or the Northern Mariana Islands for care and services described in paragraphs (1) through (25) of section 1396d(a) of this title.

(k) Repealed. Pub.L. 103-66, Title XIII, § 13611(d)(1)(C), Aug. 10, 1993, 107 Stat. 627

(l) Description of group

(1) Individuals described in this paragraph are—

(A) women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy),

(B) infants under one year of age,

(C) children children who have attained one year of age but have not attained 6 years of age, and

(D) children born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of

age, who are not described in any of subclauses (I) through (III) of subsection (a)(10)(A)(i) of this section and whose family income does not exceed the income level established by the State under paragraph (2) for a family size equal to the size of the family, including the woman, infant, or child.

(2) (A)

(i) For purposes of paragraph (1) with respect to individuals described in subparagraph (A) or (B) of that paragraph, the State shall establish an income level which is a percentage (not less than the percentage provided under clause (ii) and not more than 185 percent) of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

(ii) The percentage provided under this clause, with respect to eligibility for medical assistance on or after—

(I) July 1, 1989, is 75 percent, or, if greater, the percentage provided under clause (iii), and

(II) April 1, 1990, 133 percent, or, if greater, the percentage provided under clause (iv).

(iii) In the case of a State which, as of July 1, 1988, has elected to provide, and provides, medical assistance to individuals described in this subsection or has enacted legislation authorizing, or appropriating funds, to provide such assistance to such individuals before July 1, 1989, the percentage provided under clause (ii)(I) shall not be less than—

(I) the percentage specified by the State in an

amendment to its State plan (whether approved or not) as of July 1, 1988, or

(II) if no such percentage is specified as of July 1, 1988, the percentage established under the State's authorizing legislation or provided for under the State's appropriations; but in no case shall this clause require the percentage provided under clause (ii)(I) to exceed 100 percent.

(iv) In the case of a State which, as of December 19, 1989, has established under clause (i), or has enacted legislation authorizing, or appropriating funds, to provide for, a percentage (of the income official poverty line) that is greater than 133 percent, the percentage provided under clause (ii) for medical assistance on or after April 1, 1990, shall not be less than—

(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of December 19, 1989, or

(II) if no such percentage is specified as of December 19, 1989, the percentage established under the State's authorizing legislation or provided for under the State's appropriations.

(B) For purposes of paragraph (1) with respect to individuals described in subparagraph (C) of such paragraph, the State shall establish an income level which is equal to 133 percent of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.

(C) For purposes of paragraph (1) with respect to individuals described in subparagraph (D) of that paragraph, the State shall establish an income level which is equal to 100 percent of the income official poverty line

described in subparagraph (A) applicable to a family of the size involved.

(3) Notwithstanding subsection (a)(17) of this section, for individuals who are eligible for medical assistance because of subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX) of this section—

(A) application of a resource standard shall be at the option of the State;

(B) any resource standard or methodology that is applied with respect to an individual described in subparagraph (A) of paragraph (1) may not be more restrictive than the resource standard or methodology that is applied under subchapter XVI of this chapter;

(C) any resource standard or methodology that is applied with respect to an individual described in subparagraph (B), (C), or (D) of paragraph (1) may not be more restrictive than the corresponding methodology that is applied under the State plan under part A of subchapter IV of this chapter;

(D) the income standard to be applied is the appropriate income standard established under paragraph (2); and

(E) family income shall be determined in accordance with the methodology employed under the State plan under part A or E of subchapter IV of this chapter (except to the extent such methodology is inconsistent with clause (D) of subsection (a)(17) of this section), and costs incurred for medical care or for any other type of remedial care shall not be taken into account.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17) of this section, require or permit such treatment for other individuals.

(4) (A) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1315 of this title, the Secretary shall require the State to provide medical assistance for pregnant women and infants under age 1 described in subsection (a)(10)(A)(i)(IV) of this section and for children described in subsection (a)(10)(A)(i)(VI) or subsection (a)(10)(A)(i)(VII) of this section in the same manner as the State would be required to provide such assistance for such individuals if the State had in effect a plan approved under this subchapter.

(B) In the case of a State which is not one of the 50 States or the District of Columbia, the State need not meet the requirement of subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), or (a)(10)(A)(i)(VII) of this section and, for purposes of paragraph (2)(A), the State may substitute for the percentage provided under clause (ii) of such paragraph any percentage.

(m) Description of individuals

(1) Individuals described in this paragraph are individuals—

(A) who are 65 years of age or older or are disabled individuals (as determined under section 1382c(a)(3) of this title),

(B) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program, except as provided in paragraph 2(C)) does not exceed an income level established by the State consistent with paragraph (2)(A), and

(C) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed (except as provided in

paragraph (2)(B)) the maximum amount of resources that an individual may have and obtain benefits under that program.

(2) (A) The income level established under paragraph (1)(B) may not exceed a percentage (not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

(B) In the case of a State that provides medical assistance to individuals not described in subsection (a)(10)(A) of this section and at the State's option, the State may use under paragraph (1)(C) such resource level (which is higher than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in subsection (a)(10)(A) of this section.

(C) The provisions of section 1396d(p)(2)(D) of this title shall apply to determinations of income under this subsection in the same manner as they apply to determinations of income under section 1396d(p) of this title.

(3) Notwithstanding subsection (a)(17) of this section, for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(X) of this section—

(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

(B) except as provided in section 1382a(b)(4)(B)(ii) of this title, costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17) of this section, require or permit such treatment for other individuals.

(4) Notwithstanding subsection (a)(17) of this section, for qualified medicare beneficiaries described in section 1396d(p)(1) of this title—

(A) the income standard to be applied is the income standard described in section 1396d(p)(1)(B) of this title, and

(B) except as provided in section 1382a(b)(4)(B)(ii) of this title, costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17) of this section, require or permit such treatment for other individuals.

(n) Payment amounts

In the case of medical assistance furnished under this subchapter for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII of this chapter with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

(o) Certain benefits disregarded for purposes of determining post-eligibility contributions

Notwithstanding any provision of subsection (a) of this

section to the contrary, a State plan under this subchapter shall provide that any supplemental security income benefits paid by reason of subparagraph (E) or (G) of section 1382(e)(1) of this title to an individual who—

(1) is eligible for medical assistance under the plan, and

(2) is in a hospital, skilled nursing facility, or intermediate care facility at the time such benefits are paid,

will be disregarded for purposes of determining the amount of any post- eligibility contribution by the individual to the cost of the care and services provided by the hospital, skilled nursing facility, or intermediate care facility.

(p) Exclusion power of State; exclusion as prerequisite for medical assistance payments; "exclude" defined

(1) In addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this subchapter for any reason for which the Secretary could exclude the individual or entity from participation in a program under subchapter XVIII of this chapter under section 1320a-7, 1320a-7a, or 1395cc(b)(2) of this title.

(2) In order for a State to receive payments for medical assistance under section 1396b(a) of this title, with respect to payments the State makes to a health maintenance organization (as defined in section 1396b(m) of this title) or to an entity furnishing services under a waiver approved under section 1396n(b)(1) of this title, the State must provide that it will exclude from participation, as such an organization or entity, any organization or entity that—

(A) could be excluded under section 1320a-7(b)(8) of this title (relating to owners and managing employees who have been convicted of certain crimes or received other sanctions),

(B) has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1320a-7(b)(8)(B) of this title, or

(C) employs or contracts with any individual or entity that is excluded from participation under this subchapter under section 1320a-7 or 1320a-7a of this title for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services.

(3) As used in this subsection, the term "exclude" includes the refusal to enter into or renew a participation agreement or the termination of such an agreement.

(q) Minimum monthly personal needs allowance deduction; "institutionalized individual or couple" defined

(1) (A) In order to meet the requirement of subsection (a)(50) of this section, the State plan must provide that, in the case of an institutionalized individual or couple described in subparagraph (B), in determining the amount of the individual's or couple's income to be applied monthly to payment for the cost of care in an institution, there shall be deducted from the monthly income (in addition to other allowances otherwise provided under the State plan) a monthly personal needs allowance—

(i) which is reasonable in amount for clothing and other personal needs of the individual (or couple) while in an institution, and

(ii) which is not less (and may be greater) than the minimum monthly personal needs allowance described in paragraph (2).

(B) In this subsection, the term "institutionalized individual or couple" means an individual or married couple—

(i) who is an inpatient (or who are inpatients) in a medical institution or nursing facility for which payments are made under this subchapter throughout a month, and

(ii) who is or are determined to be eligible for medical assistance under the State plan.

(2) The minimum monthly personal needs allowance described in this paragraph [FN4] is $30 for an institutionalized individual and $60 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).

(r) Disregarding payments for certain medical expenses by institutionalized individuals

(1) For purposes of sections 1396a(a)(17) and 1396r-5(d)(1)(D) of this title and for purposes of a waiver under section 1396n of this title, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver there shall be disregarded reparation payments made by the Federal Republic of Germany and, there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) medicare and other health insurance premiums, deductibles, or coinsurance, and

(ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this subchapter, subject to reasonable limits the

State may establish on the amount of these expenses.

(2) (A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), (a)(10)(A)(ii), (a)(10)(C)(i)(III), or (f) of this section or under section 1396d(p) of this title may be less restrictive, and shall be no more restrictive, than the methodology—

(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under subchapter XVI of this chapter, or

(ii) in the case of other groups, under the State plan most closely categorically related.

(B) For purposes of this subsection and subsection (a)(10) of this section, methodology is considered to be "no more restrictive" if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.

(s) Adjustment in payment for hospital services furnished to low-income children under age of 6 years

In order to meet the requirements of subsection (a)(55) of this section, the State plan must provide that payments to hospitals under the plan for inpatient hospital services furnished to infants who have not attained the age of 1 year, and to children who have not attained the age of 6 years and who receive such services in a disproportionate share hospital described in section 1396r- 4(b)(1) of this title, shall—

(1) if made on a prospective basis (whether per diem, per case, or otherwise) provide for an outlier adjustment in

payment amounts for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay,

(2) not be limited by the imposition of day limits with respect to the delivery of such services to such individuals, and

(3) not be limited by the imposition of dollar limits (other than such limits resulting from prospective payments as adjusted pursuant to paragraph (1)) with respect to the delivery of such services to any such individual who has not attained their first birthday (or in the case of such an individual who is an inpatient on his first birthday until such individual is discharged).

(t) Authority of Secretary; limitations

Nothing in this subchapter (including sections 1396b(a) and 1396d(a) of this title) shall be construed as authorizing the Secretary to deny or limit payments to a State for expenditures, for medical assistance for items or services, attributable to taxes of general applicability imposed with respect to the provision of such items or services.

(u) Qualified COBRA continuation beneficiaries

(1) Individuals described in this paragraph are individuals—

(A) who are entitled to elect COBRA continuation coverage (as defined in paragraph (3)).

(B) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program) does not exceed 100 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance

with section 9902(2) of this title) applicable to a family of the size involved;

(C) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program, and

(D) with respect to whose enrollment for COBRA continuation coverage the State has determined that the savings in expenditures under this subchapter resulting from such enrollment is likely to exceed the amount of payments for COBRA premiums made.

(2) For purposes of subsection (a)(10)(F) of this section and this subsection, the term"COBRA premiums" means the applicable premium imposed with respect to COBRA continuation coverage.

(3) In this subsection, the term "COBRA continuation coverage" means coverage under a group health plan provided by an employer with 75 or more employees provided pursuant to title XXII of the Public Health Service Act [42 U.S.C.A. § 300bb-1 et seq.] section 4980B of Title 26, or title VI of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1161 et seq.]

(4) Notwithstanding subsection (a)(17) of this section, for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(XI) of this section—

(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

(B) except as provided in section 1382a(b)(4)(B)(ii) of this title, costs incurred for medical care or for any other type

of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(10)(B) or (a)(17) of this section, require or permit such treatment for other individuals.

(v) State agency determination of disability and blindness and provision of medical assistance prior to final determination by Administration

(1) A State plan may provide for the making of determinations of disability or blindness for the purpose of determining eligibility for medical assistance under the State plan by the single State agency or its designee, and make medical assistance available to individuals whom it finds to be blind or disabled and who are determined otherwise eligible for such assistance during the period of time prior to which a final determination of disability or blindness is made by the Social Security Administration with respect to such an individual. In making such determinations, the State must apply the definitions of disability and blindness found in section 1382c(a) of this title.

(w) Maintenance of written policies and procedures respecting advance directives

(1) For purposes of subsection (a)(57) of this section and sections 1396b(m)(1)(A) and 1396r(c)(2)(E) of this title, the requirement of this subsection is that a provider or organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

(A) to provide written information to each such individual concerning—

(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

(ii) the provider's or organization's written policies respecting the implementation of such rights;

(B) to document in the individual's medical record whether or not the individual has executed an advance directive;

(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives; and

(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

(B) in the case of a nursing facility, at the time of the individual's admission as a resident,

(C) in the case of a provider of home health care or personal care services, in advance of the individual coming under the care of the provider,

(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

(E) in the case of a health maintenance organization, at the time of enrollment of the individual with the organization.

(3) Nothing in this section shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.

(4) In this subsection, the term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

(x) Physician identifier system; establishment

The Secretary shall establish a system, for implementation by not later than July 1, 1991, which provides for a unique identifier for each physician who furnishes services for which payment may be made under a State plan approved under this subchapter.

(y) Intermediate sanctions for psychiatric hospitals

(1) In addition to any other authority under State law, where a State determines that a psychiatric hospital which is certified for participation under its plan no longer meets the requirements for a psychiatric hospital (referred to in section 1396d(h) of this title) and further finds that the hospital's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall terminate the hospital's participation under the State plan; or

(B) do not immediately jeopardize the health and safety of its patients, the State may terminate the hospital's participation under the State plan, or provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding, or both.

(2) Except as provided in paragraph (3), if a psychiatric hospital described in paragraph (1)(B) has not complied with the requirements for a psychiatric hospital under this subchapter—

(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period, or

(B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no Federal financial participation shall be provided under section 1396b(a) of this title with respect to further services provided in the hospital until the State finds that the hospital is in compliance with the requirements of this subchapter.

(3) The Secretary may continue payments, over a period of not longer than 6 months from the date the hospital is found to be out of compliance with such requirements, if—

(A) the State finds that it is more appropriate to take alternative action to assure compliance of the hospital with the requirements than to terminate the certification of the hospital,

(B) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(C) the State agrees to repay to the Federal Government payments received under this paragraph if the corrective action is not taken in accordance with the approved plan and timetable.

(z) Optional coverage of TB-related services

(1) Individuals described in this paragraph are individuals not described in subsection (a)(10)(A)(i) of this section—

(A) who are infected with tuberculosis;

(B) whose income (as determined under the State plan under this subchapter with respect to disabled individuals) does not exceed the maximum amount of income a disabled individual described in subsection (a)(10)(A)(i) of this section may have and obtain medical assistance under the plan; and

(C) whose resources (as determined under the State plan under this subchapter with respect to disabled individuals) do not exceed the maximum amount of resources a disabled individual described in subsection (a)(10)(A)(i) of this section may have and obtain medical assistance under the plan.

(2) For purposes of subsection (a)(10) of this section, the term "TB-related services" means each of the following services relating to treatment of infection with tuberculosis:

(A) Prescribed drugs.

(B) Physicians' services and services described in section 1396d(a)(2) of this title.

(C) Laboratory and X-ray services (including services to confirm the presence of infection).

(D) Clinic services and Federally-qualified health center services.

(E) Case management services (as defined in section 1396n(g)(2) of this title).

(F) Services (other than room and board) designed to encourage completion of regimens of prescribed drugs by out-patients, including services to observe directly the intake of prescribed drugs.

2. 42 U.S.C. § 1396d

§ 1396d. Definitions

For purposes of this subchapter—

(a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1) of this section, if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the

State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, who are—

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,

(ii) relatives specified in section 606(b)(1) of this title with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of subchapter IV of this chapter,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under subchapter I, X, XIV, or XVI of this chapter,

(vii) blind or disabled as defined in section 1382c of this title, with respect to States not eligible to participate in the State plan program established under subchapter XVI of this chapter,

(viii) pregnant women,

(ix) individuals provided extended benefits under section 1396r-6 of this title,

(x) individuals described in section 1396a(u)(1) of this title, or

(xi) individuals described in section 1396a(z)(1) of this title, but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for mental diseases);

(2) (A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)(1) of this section) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)(1) of this section) and which are otherwise included in the plan, and (C) Federally- qualified health center services (as defined in subsection (l)(2) of this section) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan;

(3) other laboratory and X-ray services;

(4) (A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; (B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r) of this section) for individuals who are eligible under the plan and are under the age of 21; and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

(5) (A) physicians' services furnished by a physician (as defined in section 1395x(r)(1) of this title), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, and (B) medical and surgical services furnished by a dentist (described in section 1395x(r)(2) of

this title) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause (A) if furnished by a physician (as defined in section 1395x(r)(1) of this title);

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;

(14) inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases;

(15) services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with section 1396a(a)(31)(A) of this title, to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h) of this section;

(17) services furnished by a nurse-midwife (as defined in section 1395x(gg) of this title) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider, and without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle;

(18) hospice care (as defined in subsection (o) of this section);

(19) case-management services (as defined in section 1396n(g)(2) of this title) and TB-related services described in section 1396a(z)(2)(F) of this title;

(20) respiratory care services (as defined in section 1396a(e)(9)(C) of this title);

(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regula-

tory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider;

(22) home and community care (to the extent allowed and as defined in section 1396t of this title) for functionally disabled elderly individuals; and

(23) community supported living arrangements services (to the extent allowed and as defined in section 1396u of this title);

(24) personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location; and

(25) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under subchapter I, X, XIV, or XVI of this chapter), and such person is determined, under such a State plan, to be essential to the well-being of such individual. The payment described in the first sentence may include expenditures for medicare cost-sharing and for premiums under part B of subchapter XVIII of this chapter for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under subchapters I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under subchapter XVIII of this chapter who are not enrolled under part B of subchapter XVIII of this chapter, other insurance premiums for medical or any other type of remedial care or the cost thereof. No service (including counseling) shall be excluded from the definition of "medical assistance" solely because it is provided as a treatment service for alcoholism or drug dependency.

(b) Federal medical assistance percentage; State percentage; Indian health care percentage

The term "Federal medical assistance percentage" for any

State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 per centum. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1301(a)(8)(B) of this title. Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 1603 of Title 25).

(c) Nursing facility

For definition of the term "nursing facility", see section 1396r(a) of this title.

(d) Intermediate care facility for mentally retarded

The term "intermediate care facility for the mentally retarded" means an institution (or distinct part thereof) for the mentally retarded or persons with related conditions if—

(1) the primary purpose of such institution (or distinct part thereof) is to provide health or rehabilitative services for mentally retarded individuals and the institution meets such standards as may be prescribed by the Secretary;

(2) the mentally retarded individual with respect to whom

a request for payment is made under a plan approved under this subchapter is receiving active treatment under such a program; and

(3) in the case of a public institution, the State or political subdivision responsible for the operation of such institution has agreed that the non- Federal expenditures in any calendar quarter prior to January 1, 1975, with respect to services furnished to patients in such institution (or distinct part thereof) in the State will not, because of payments made under this subchapter, be reduced below the average amount expended for such services in such institution in the four quarters immediately preceding the quarter in which the State in which such institution is located elected to make such services available under its plan approved under this subchapter.

(e) Physicians' services

In the case of any State the State plan of which (as approved under this subchapter)—

(1) does not provide for the payment of services (other than services covered under section 1396a(a)(12) of this title) provided by an optometrist; but

(2) at a prior period did provide for the payment of services referred to in paragraph (1); the term "physicians' services" (as used in subsection (a)(5) of this section) shall include services of the type which an optometrist is legally authorized to perform where the State plan specifically provides that the term "physicians' services", as employed in such plan, includes services of the type which an optometrist is legally authorized to perform, and shall be reimbursed whether furnished by a physician or an optometrist.

(f) Nursing facility services

For purposes of this subchapter, the term "nursing facility services" means services which are or were required to be given an individual who needs or needed on a daily basis nursing care (provided directly by or requiring the supervision of nursing personnel) or other rehabilitation services which as a practical matter can only be provided in a nursing facility on an inpatient basis.

(g) Chiropractors' services

If the State plan includes provision of chiropractors' services, such services include only—

(1) services provided by a chiropractor (A) who is licensed as such by the State and (B) who meets uniform minimum standards promulgated by the Secretary under section 1395x(r)(5) of this title; and

(2) services which consist of treatment by means of manual manipulation of the spine which the chiropractor is legally authorized to perform by the State.

(h) Inpatient psychiatric hospital services for individuals under age 21

(1) For purposes of paragraph (16) of subsection (a) of this section, the term "inpatient psychiatric hospital services for individuals under age 21" includes only—

(A) inpatient services which are provided in an institution (or distinct part thereof) which is a psychiatric hospital as defined in section 1395x(f) of this title or in another inpatient setting that the Secretary has specified in regulations;

(B) inpatient services which, in the case of any individual (i) involve active treatment which meets such stan-

dards as may be prescribed in regulations by the Secretary, and (ii) a team, consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof, has determined are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, to the extent that eventually such services will no longer be necessary; and

(C) inpatient services which, in the case of any individual, are provided prior to (i) the date such individual attains age 21, or (ii) in the case of an individual who was receiving such services in the period immediately preceding the date on which he attained age 21, (I) the date such individual no longer requires such services, or (II) if earlier, the date such individual attains age 22;

(2) Such term does not include services provided during any calendar quarter under the State plan of any State if the total amount of the funds expended, during such quarter, by the State (and the political subdivisions thereof) from non-Federal funds for inpatient services included under paragraph (1), and for active psychiatric care and treatment provided on an outpatient basis for eligible mentally ill children, is less than the average quarterly amount of the funds expended, during the 4-quarter period ending December 31, 1971, by the State (and the political subdivisions thereof) from non-Federal funds for such services.

(i) Institution for mental diseases

The term "institution for mental diseases" means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

(j) State supplementary payment

The term "State supplementary payment" means any cash payment made by a State on a regular basis to an individual who is receiving supplemental security income benefits under subchapter XVI of this chapter or who would but for his income be eligible to receive such benefits, as assistance based on need in supplementation of such benefits (as determined by the Commissioner of Social Security), but only to the extent that such payments are made with respect to an individual with respect to whom supplemental security income benefits are payable under subchapter XVI of this chapter, or would but for his income be payable under that subchapter.

(k) Supplemental security income benefits

Increased supplemental security income benefits payable pursuant to section 211 of Public Law 93-66 shall not be considered supplemental security income benefits payable under subchapter XVI of this chapter.

(l) Rural health clinics

(1) The terms "rural health clinic services" and "rural health clinic" have the meanings given such terms in section 1395x(aa) of this title, except that (A) clause (ii) of section 1395x(aa)(2) of this title shall not apply to such terms, and (B) the physician arrangement required under section 1395x(aa)(2)(B) of this title shall only apply with respect to rural health clinic services and, with respect to other ambulatory care services, the physician arrangement required shall be only such as may be required under the State plan for those services.

(2)

(A) The term "Federally-qualified health center services" means services of the type described in subpara-

graphs (A) through (C) of section 1395x(aa)(1) of this title when furnished to an individual as a patient of a Federally- qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in section 1395x(aa)(2)(B) of this title is deemed a reference to a Federally-qualified health center or a physician at the center, respectively.

(B) The term "Federally-qualified health center" means an entity which—

(i) is receiving a grant under section 254b, 254c, 256, or 256a of this title,

(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and

(II) meets the requirements to receive a grant under section 254b, 254c, 256, or 256a of this title,

(iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant, or

(iv) was treated by the Secretary, for purposes of part B of subchapter XVIII of this chapter, as a comprehensive Federally funded health center as of January 1, 1990; and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) [25 U.S.C.A. § 450f et seq.] or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act [25 U.S.C.A. § 1651 et seq.] for the provision of primary health services. In applying clause (ii), the Secretary may waive any requirement referred to in such clause for up to 2 years for good cause shown.

(m) Qualified family member

(1) Subject to paragraph (2), the term "qualified family member" means an individual (other than a qualified pregnant woman or child, as defined in subsection (n) of this section) who is a member of a family that would be receiving aid under the State plan under part A of subchapter IV of this chapter pursuant to section 607 of this title if the State had not exercised the option under section 607(b)(2)(B)(i) of this title.

(2) No individual shall be a qualified family member for any period after September 30, 1998.

(n) "Qualified pregnant woman or child" defined

The term "qualified pregnant woman or child" means—

(1) a pregnant woman who—

(A) would be eligible for aid to families with dependent children under part A of subchapter IV of this chapter (or would be eligible for such aid if coverage under the State plan under part A of subchapter IV of this chapter included aid to families with dependent children of unemployed parents pursuant to section 607 of this title) if her child had been born and was living with her in the month such aid would be paid, and such pregnancy has been medically verified;

(B) is a member of a family which would be eligible for aid under the State plan under part A of subchapter IV of this chapter pursuant to section 607 of this title if the plan required the payment of aid pursuant to such section; or

(C) otherwise meets the income and resources requirements of a State plan under part A of subchapter IV of this chapter; and

(2) a child who has not attained the age of 19, who was born after September 30, 1983 (or such earlier date as the State may designate), and who meets the income and resources requirements of the State plan under part A of subchapter IV of this chapter.

(o) Optional hospice benefits

(1)

(A) Subject to subparagraph (B), the term "hospice care" means the care described in section 1395x(dd)(1) of this title furnished by a hospice program (as defined in section 1395x(dd)(2) of this title) to a terminally ill individual who has voluntarily elected (in accordance with paragraph (2)) to have payment made for hospice care instead of having payment made for certain benefits described in section 1395d(d)(2)(A) of this title and for which payment may otherwise be made under subchapter XVIII of this chapter and intermediate care facility services under the plan. For purposes of such election, hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but the only payment made under the State plan shall be for the hospice care.

(B) For purposes of this subchapter, with respect to the definition of hospice program under section 1395x(dd)(2) of this title, the Secretary may allow an agency or organization to make the assurance under subparagraph (A)(iii) of such section without taking into account any individual who is afflicted with acquired immune deficiency syndrome (AIDS).

(2) An individual's voluntary election under this subsection—

(A) shall be made in accordance with procedures that

are established by the State and that are consistent with the procedures established under section 1395d(d)(2) of this title;

(B) shall be for such a period or periods (which need not be the same periods described in section 1395d(d)(1) of this title) as the State may establish; and

(C) may be revoked at any time without a showing of cause and may be modified so as to change the hospice program with respect to which a previous election was made.

(3) In the case of an individual—

(A) who is residing in a nursing facility or intermediate care facility for the mentally retarded and is receiving medical assistance for services in such facility under the plan,

(B) who is entitled to benefits under part A of subchapter XVIII of this chapter and has elected, under section 1395d(d) of this title, to receive hospice care under such part, and

(C) with respect to whom the hospice program under such subchapter and the nursing facility or intermediate care facility for the mentally retarded have entered into a written agreement under which the program takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual, instead of any payment otherwise made under the plan with respect to the facility's services, the State shall provide for payment to the hospice program of an amount equal to the additional amount described in section 1396a(a)(13)(D) of this title and, if the individual is an individual described in section 1396a(a)(10)(A) of this title, shall pro-

vide for payment of any coinsurance amounts imposed under section 1395e(a)(4) of this title.

(p) Qualified medicare beneficiary; medicare cost-sharing

(1) The term "qualified medicare beneficiary" means an individual—

(A) who is entitled to hospital insurance benefits under part A of subchapter XVIII of this chapter (including an individual entitled to such benefits pursuant to an enrollment under section 1395i-2 of this title, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1395i-2a of this title),

(B) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program except as provided in paragraph (2)(D)) does not exceed an income level established by the State consistent with paragraph (2), and

(C) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program.

(2)

(A) The income level established under paragraph (1)(B) shall be at least the percent provided under subparagraph (B) (but not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

(B) Except as provided in subparagraph (C), the percent

provided under this clause, with respect to eligibility for medical assistance on or after—

(i) January 1, 1989, is 85 percent,

(ii) January 1, 1990, is 90 percent, and

(iii) January 1, 1991, is 100 percent.

(C) In the case of a State which has elected treatment under section 1396a(f) of this title and which, as of January 1, 1987, used an income standard for individuals age 65 or older which was more restrictive than the income standard established under the supplemental security income program under subchapter XVI of this chapter, the percent provided under subparagraph (B), with respect to eligibility for medical assistance on or after—

(i) January 1, 1989, is 80 percent,

(ii) January 1, 1990, is 85 percent,

(iii) January 1, 1991, is 95 percent, and

(iv) January 1, 1992, is 100 percent.

(D)

(I) In determining under this subsection the income of an individual who is entitled to monthly insurance benefits under subchapter II of this chapter for a transition month (as defined in clause (ii)) in a year, such income shall not include any amounts attributable to an increase in the level of monthly insurance benefits payable under such subchapter which have occurred pursuant to section 415(i) of this title for benefits payable for months beginning with December of the previous year.

(ii) For purposes of clause (i), the term "transition month" means each month in a year through the month following the month in which the annual revi-

sion of the official poverty line, referred to in subparagraph (A), is published.

(3) The term "medicare cost-sharing" means the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

(A)(i) premiums under section 1395i-2 or 1395i-2a of this title, and

(ii) premiums under section 1395r of this title,

(B) Coinsurance under subchapter XVIII of this chapter (including coinsurance described in section 1395e of this title).

(C) Deductibles established under subchapter XVIII of this chapter (including those described in section 1395e and section 1395l(b) of this title).

(D) The difference between the amount that is paid under section 1395l(a) of this title and the amount that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent".

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1395mm of this title.

(4) Notwithstanding any other provision of this subchapter, in the case of a State (other than the 50 States and the District of Columbia)—

(A) the requirement stated in section 1396a(a)(10)(E) of this title shall be optional, and

(B) for purposes of paragraph (2), the State may substi-

tute for the percent provided under subparagraph (B) or 1396a(a)(10)(E)(iii) [FN2] of such paragraph any percent.

In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1315 of this title, the Secretary shall require the State to meet the requirement of section 1396a(a)(10)(E) of this title in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this subchapter.

(q) Qualified severely impaired individual

The term "qualified severely impaired individual" means an individual under age 65—

(1) who for the month preceding the first month to which this subsection applies to such individual—

(A) received (i) a payment of supplemental security income benefits under section 1382(b) of this title on the basis of blindness or disability, (ii) a supplementary payment under section 1382e of this title or under section 212 of Public Law 93-66 on such basis, (iii) a payment of monthly benefits under section 1382h(a) of this title, or (iv) a supplementary payment under section 1382e(c)(3) of this title, and

(B) was eligible for medical assistance under the State plan approved under this subchapter; and

(2) with respect to whom the Commissioner of Social Security determines that—

(A) the individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, continues to meet all non- disability-related requirements for eligibility for benefits under subchapter XVI of this chapter,

(B) the income of such individual would not, except for his earnings, be equal to or in excess of the amount which would cause him to be ineligible for payments under section 1382(b) of this title (if he were otherwise eligible for such payments),

(C) the lack of eligibility for benefits under this subchapter would seriously inhibit his ability to continue or obtain employment, and

(D) the individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under subchapter XVI of this chapter (including any federally administered State supplementary payments), this subchapter, and publicly funded attendant care services (including personal care assistance) that would be available to him in the absence of such earnings.

In the case of an individual who is eligible for medical assistance pursuant to section 1382h(b) of this title in June, 1987, the individual shall be a qualified severely impaired individual for so long as such individual meets the requirements of paragraph (2).

(r) Early and periodic screening, diagnostic, and treatment services

The term "early and periodic screening, diagnostic, and treatment services" means the following items and services:

(1) Screening services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care

and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

(B) which shall at a minimum include—

(i) a comprehensive health and developmental history (including assessment of both physical and mental health development),

(ii) a comprehensive unclothed physical exam,

(iii) appropriate immunizations (according to the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines) according to age and health history,

(iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and

(v) health education (including anticipatory guidance).

(2) Vision services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

(3) Dental services—

(A) which are provided—

(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

(4) Hearing services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

(5) Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this subchapter shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this subchapter in early and periodic screening, diagnostic, and treatment services.

(s) Qualified disabled and working individual

The term "qualified disabled and working individual" means an individual—

(1) who is entitled to enroll for hospital insurance benefits under part A of subchapter XVIII of this chapter under section 1395i-2a of this title;

(2) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program) does not exceed 200 percent of the official poverty line (as defined by the Office of Management and Budget and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved;

(3) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual or a couple (in the case of an individual with a spouse) may have and obtain benefits for supplemental security income benefits under subchapter XVI of this chapter; and

(4) who is not otherwise eligible for medical assistance under this subchapter.

3. Public Law 103-112, Section 509

SEC. 509. None of the funds appropriated under this Act shall be expended for any abortion except when it is made known to the Federal entity or official to which funds are appropriated under this Act that such procedure is necessary to save the life of the mother or that the pregnancy is the result of an act of rape or incest.

This Act may be cited as the "Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1994".

Approved October 21, 1993.

4. 42 U.S.C. § 1302

§ 1302. Rules and regulations; (in relevant part)

(a) The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, respectively, shall make and publish such rules and regulations, not inconsistent with this chapter, as may be necessary to the efficient administration of the functions with which each is charged under this chapter.

5. Public Law 100-517, Section 9

Abortion Services; Prohibition on Certain Policy Changes

Pub. L. 100-517, § 9, Oct. 24, 1988, 102 Stat. 2583: "With respect to abortion services, the Secretary of Health and Human Services shall not promulgate or issue any regulations, policy statements, or interpretations or develop any practices concerning the performance of medically necessary procedures if such

regulations, policy statements, interpretations, or practices would be inconsistent with regulations, policy statements, interpretations, or practices in effect on the date of the enactment of this Act [Oct. 24, 1988]."

6. 42 C.F.R. § 441.202

§ 441.202 General rule.

FFP [Federal Financial Participation] is not available in expenditures for an abortion unless the conditions specified in §§ 441.203 and 441.206 are met.

[52 FR 47935, Dec. 17, 1987]

7. 42 C.F.R. § 441.203

§ 441.203 Life of the mother would be endangered.

FFP [Federal Financial Participation] is available in expenditures for an abortion when a physician has found, and certified in writing to the Medicaid agency, that on the basis of his professional judgment, the life of the mother would be endangered if the fetus were carried to term. The certification must contain the name and address of the patient.

[51 FR 41338, Nov. 14, 1986]